The Right to Health

A Human Rights Perspective with a Case Study on Greece

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Dedicated to my family

"Where after all, do universal human rights begin?
In small places, close to home- so close and so small that
they cannot be seen on any maps of the world.
Yet they are the world of the individual person; […]
Unless these rights have meaning there,
they have little meaning
anywhere."

Eleanor Roosevelt, United Nations - New York, 27 March 1958

(cited in: M.A. Baderin & R. McCorquodale, 'The International Covenant on Economic, Social and Cultural Rights: Forty Years of Development' in: M.A. Baderin & R. McCorquodale (ed.), *Economic, Social and Cultural Rights in Action*, Oxford: OUP 2007, p. 24).

ACKNOWLEDGEMENTS

The 'right to the highest attainable standard of health' ('right to health') is by now firmly enshrined in international law, despite the absence of worldwide consensus as to its meaning and its various aspects.[1] Seven decades since its initial recognition in the preamble to the Constitution of the World Health Organization (1946), the right to health has increasingly attained a prominent position at the international level. As a result, this right can be influential in the health and well-being of all individuals, especially those most in need, worldwide. Therefore, the next step is to move from its recognition to its realization and develop an understanding of the state measures required with the aim of bringing this right closer to reality. Put simply, we need to consider the normative content of the right to health and evaluate its status within national contexts. The challenge then is to learn about how human rights standards are to be operationalised in such contexts and what role, if any, these standards can play in law - policy making in order to secure the right of everyone to the highest attainable standard of health. Hence, finding this an interesting and developing area in the law practice, the focus of my research is on the national implementation of the right to health.

The conduct of this research was an interesting and a challenging project. It would not have been possible if it had not been the interest and support of a number of people. Therefore, I am utterly grateful to all those people for their inspiration, and various forms of support in this project. Importantly, I am grateful to my supervisor professor Aart Hendriks who continuously challenged me with his critical and valuable commentary and sound advice on the scope of the right to health. Having professor Aart Hendriks as my supervisor was both a pleasure and an honour.

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[1] See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 60th Sess., Agenda Item 10*, UN Doc. E/CN.4/2004/ 49/Add.1, 1 March 2004, § 15.

Finally, I would like to especially thank my parents and my sister, for their constant material and moral support, unwavering love and understanding in all possible ways at every stage of this project and beyond that. Their support and confidence provided me with the inspiration, persistence and energy to begin, continue and complete this project with great enthusiasm.

Contents

List of abbreviations

AAAQ	Availability, Accessibility, Acceptability, Quality
ACHR	American Convention on Human Rights
AfCHPR	African Charter on Human and People's Rights
AIDS	Acquired Immunodeficiency Syndrome
AP	Accountability and Participation
AP (ESC)	Additional Protocol (to the ESC)
Art.	Article
CAT	UN Committee against Torture
CEDAW	UN Convention on the Elimination of all forms of Discrimination Against Women
CERD	UN Committee on the Elimination of Racial Discrimination
CESCR	UN Committee on Economic, Social and Cultural Rights
CETS	Council of Europe Treaty Series
CFREU	Charter of Fundamental Rights of the European Union
CMW	UN Committee on the Protection of the Rights of All Migrant Workers and Members of their Families
CoE	Council of Europe
CO	Concluding Observations
CP rights	Civil and Political rights
CRC	UN Convention on the Rights of the Child
CRC Committee	UN Committee on the Rights of the Child
CRPD	UN Convention on the Rights of Persons with Disabilities
CSDH	Commission on the Social Determinants of Health

Doc.	Document
EC	European Community
ECB	European Central Bank
ECDC	European Centre for Disease Prevention and Control
ECHR	Convention for the Protection of Human Rights and Fundamental Freedoms
ECOSOC	UN Economic and Social Council
ECSR	European Committee of Social Rights
ECtHR	European Court of Human Rights
E.g.	Exempli gratia (for example)
ERRC	European Roma Rights Center
ESC	European Social Charter
ESC rights	Economic, Social and Cultural rights
ESCOR	Economic and Social Council Official Records
ESY	Ethniko Systima Ygeias
ETS	European Treaty Series
EU	European Union
GA	UN General Assembly
GAOR	General Assembly Official Records
GC	General Comment
GDP	Gross Domestic Product
GTZ	Gesellschaft für Technische Zusammenarbeit
HCDCP	Hellenic Center for Disease Control and Prevention
HDPA	Hellenic Data Protection Authority
HIV	Human Immunodeficiency Virus
HRL	Human Rights Law
HRC	UN Human Rights Council
ICCPR	UN International Covenant on Civil and Political Rights
ICERD	UN International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	UN International Covenant on Economic, Social and Cultural Rights

ICPD	International Conference on Population and Development
I.e.	Id est (namely)
IHR	International Health Regulations
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
LLM	Master of Laws
MDGs	Millennium Development Goals
MdM	Médecins du Monde
MoU	Memorandum of Understanding
MSc	Master of Science
MSF	Médecins Sans Frontières
MWC	UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
NQHR	Netherlands Quarterly of Human Rights
NGO	Non Governmental Organization
OAS	Organization of American States
OAU	Organization of African Unity
OECD	Organization for Economic Co-operation and Development
OHCHR	United Nations Office of the High Commissioner for Human Rights
OP	Optional Protocol
PD	Presidential Decree
REC	Recommendation
RES	Resolution
RESC	Revised European Social Charter
SDGs	Sustainable Development Goals
TFEU	Treaty on the Functioning of the European Union
UDHR	Universal Declaration of Human Rights
UK	United Kingdom
UN	United Nations
UNCAC	United Nations Convention Against Corruption

UNCHR	United Nations Commission on Human Rights
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCHR	United Nations High Commissioner of Human Rights
UNICEF	United Nations Children's Fund
UNTS	United Nations Treaty Series
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

1 General Introduction

1.1. BACKGROUND AND PROBLEM

Regardless of age, gender, legal status, socio-economic or ethnic background, health is a significant aspect of the human condition. Health together with social determinants (e.g., adequate living conditions, housing etc.) provides the foundations for an individual leading a decent life. Illuminating is the argument that '… ill health is both a cause and a consequence of poverty: sick people are more likely to become poor and the poor are more vulnerable to disease and disability… Good health is central to creating and sustaining the capabilities that poor people need to escape from poverty. A key asset of the poor, good health contributes to their greater economic security. Good health is not just an outcome of development: it is a way of achieving development…'.[1] Thereby, the formulation of health as a right is an essential element for ensuring the human well-being and for living a life in dignity.[2]

Seven decades since its initial recognition in the preamble to the Constitution of the World Health Organization (henceforth: WHO), the definition of health as a right has gained growing supremacy at the international level, despite the absence of consensus on its existence as a legally binding right, its normative content and its implementation in practice.[3] In 1946, the WHO was the first international

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1 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc. E/CN.4/2003/58, 13 February 2003, §§ 45-46.

2 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN GA, 69th Sess., Agenda Item 69 (b),* UN Doc. A/69/299, 11 August 2014, §§ 71 & seq.

3 As regards views that embrace the right to health and its particular aspects, see, e.g., P. Hunt & G. Backman, 'Health Systems and the Right to the Highest Attainable Standard of Health'

organization that stressed that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[4] Since then, the right to health is firmly enshrined in international law.[5] In fact, health as a right has been reiterated in numerous legally binding international and regional human rights treaties as well as in national constitutions worldwide (see chapter 2). Most of these human rights treaty provisions define State obligations concerning a wide range of health-related issues, *inter alia* health care, reproductive health, child health, environmental health and occupational health (see chapter 2). Meanwhile, the recognition of health as a right represents a significant step in protecting people's health and well-being and is indispensable for the exercise of other human rights.[6] Indeed, it is acknowledged that the increasing significance of health as a right is partly due to its connection to other human rights, as it is often dealt with by adjudicatory bodies *via* civil and political rights (e.g., the right to life).[7] Nonetheless, to the extent that the right to health constitutes itself a basis for lodging claims, courts or other (quasi)-judicial bodies affirm that States are required to ensure a minimum level of health protection, (equal access to) essential health care and satisfaction of basic human needs.[8]

Yet, despite the growing international recognition of health as a right, in practice the issue of how this right will be effectively realized by States is still a

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Health and Human Rights 2008, Volume 10 (1), pp. 81-92, pp. 84-85 (core obligations); D. Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights*, Oxford: Oxford University Press 2007, pp. 223-224 (minimum core of socio-economic rights); As regards views that are critical of the right to health and its particular aspects, see, e.g., T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, 30(3), pp. 643-662; K.G. Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' *The Yale Journal of International Law* 2008, volume 33, pp. 113-175; Note also that 'skepticism' as to the meaning, elements and practice (e.g., universality) exist for all human rights, see, e.g., Ch. R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, pp. 2-7.

4 WHO Constitution adopted by the International Conference - New York 1946, preamble.

5 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 60th Sess., Agenda Item 10*, UN Doc. E/CN.4/2004/49/Add.1, 1 March 2004, § 15.

6 UN CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000, § 1.

7 See, e.g., A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, Volume 5, pp. 389-408, p. 402.

8 Ibid., p. 403.

challenge.[9] In fact, in 2012 about 18,000 children died each day from diseases that were to a large degree preventable and curable.[10] The realization process implies action mainly on the part of States, as being primary duty holders under human rights law, to translate commitments into decisions with a view to defining, determining and having a positive impact on people's well-being.[11] In essence, the recognition of health as a right at the national level establishes a primary and ultimate responsibility for the State in ensuring access to health care and the preconditions of health for every individual within its jurisdiction.

At the same time, the effective realization of the right to health on the part of States by way of translation of human rights law into compatible national law and operational health-related policies and practices, remains a tough issue. The implementation of stringent economic policies imposed by international financial organizations, such as the International Monetary Fund (henceforth: IMF), leaves no space for national decisions for effective realization of the right to health of all individuals and especially of those who are marginalised and disadvantaged, as the health and human rights perspective is largely absent in such policies.[12] Indeed, the policies of the IMF, for instance, which *inter alia* strengthen privatization,

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9 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN GA*, 66th Sess., Agenda Item 69(b), UN Doc. A/66/254, 3 August 2011; Ibidem supra note 6, UN CESCR, § 5; CSDH, *Closing the gap in a generation: Health equity through action on social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva: WHO 2008.

10 World Health Organization, *World Health Statistics 2014*, Geneva: WHO, p. 13.

11 Ibidem supra note 3, Ch. R. Beitz 2009, p. 114; See, Convention on the Rights of the Child (CRC) (New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3) Article 2(1): 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction…'; Economic and Social Council, *Report of the High Commissioner for Human Rights on implementation of economic, social and cultural rights,* UN DOC. E/2009/90, 8 June 2009, § 34; Ibidem supra note 6, GC No. 14.

12 Working group on IMF programs, *Does the IMF constrain health spending in poor countries? Evidence and an agenda for action*, Washington, D.C.: Center for Global Development and Health Spending, June 2007; Regarding concerns about privatization in health sector, see, e.g., S. Gruskin & D. Tarantola, 'Health and Human Rights' in: R. Detels, J. McEwen, R. Beaglehole & H. Tanaka (eds), *The Oxford Textbook of Public Health*, 4th ed. Oxford: Oxford University Press 2002, pp. 311-335; See generally, M. Darrow, *Between Light and Shadow: The World Bank, the International Monetary Fund and International Human Rights Law*, Portland/Oxford: Hart Publishing 2003, p. 53 (Chapter III - the Importance of the Question: Comments on the Human Rights Impacts of the IFIs' Policies and Activities); P. O'Connell, 'The Human Right to Health in Age of Market Hegemony in: J. Harrington & M. Stuttaford

often result in the further impoverishment of poor and marginalised people; and in the widening of health inequalities within and between countries (see Part II), by increasing the well-being of some people while having severe impacts on other people's health due to the non-fulfillment of their pressing health needs.[13] On this issue, at the World Summit for Social Development, it was pointedly noted that external debts have crippled the social efforts of middle-income countries[14] in a way that increased constraints, including fiscal and political ones on States, have resulted in a reduction of the programmes and activities of these States.[15] Particularly, in some countries, the principle of universal free provision of services, involving health care, education and water supply, has been replaced by user fees and privatization.[16] As such, serious impediments to social development, several of which were identified by the Summit, still persist, such as chronic hunger, malnutrition, endemic, communicable and chronic diseases.[17]

In light of the above, we should move the discussion beyond the international formulation and dimension of the right to health and look more specifically at the definition and implementation of this right at a national level. Thereto, we need to consider and evaluate the normative content of the right to health in view of national realities and challenges (i.e., to assess the status of this right in a national context), such as poverty, privatization, embedded inequalities etc. The challenge then is to learn more about how these standards are to be operationalised in a particular national context and what role, if any, these standards can play in policy making in order to secure the right of everyone to the highest attainable standard of health. Within this overall setting, this study aims at identifying the standards in human rights law for realizing the right to health on the part of the State and how a particular country, Greece, has given effect (or not) to the right to health framework in light of its own reality and specific conditions (e.g., resource constraints, economic austerity, health sector privatization, corruption and vulnerable groups). The advancement of the realization of the right to health will be benefited from the

(ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 190-209.

13 Ibid. Note that 'health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups' (WHO definition <www.who.int/hia/about/glos>)

14 UN, *Resolution adopted by the General Assembly - S-24/2. Further initiatives for social development*, UN Doc. A/RES/S-24/2, 15 December 2000, § 41.

15 Ibid., § 42.

16 Ibid., § 36.

17 Ibid., p. 5, § 3.

attention at national level. Specifically, such an approach will help us acquire a greater understanding of the content of the right to health in practice with the ultimate aim of securing the right of everyone to the highest attainable standard of health. At the same time, the discussion of the Greek experience can assist in identifying possible 'implementation gaps'[18] and opportunities in this area and as such, it can contribute to the emerging dialogue on best-practices and shortcomings in relation to the understanding and the operationalisation of the right to health framework among different countries worldwide.[19]

Note by way of background that Greece is located at the south-east of Europe, at the southern end of the Balkan Peninsula and covers an area of 131,957 sq. km, of which 80 percent is mountainous.[20] The population of the country in 2014 was approximately 10,992,589 million, representing 2.2% of the total EU population.[21] Life expectancy at birth in Greece was at 80.7 years in 2012, half a year higher than the OECD average (80.2 years).[22] Nevertheless, life expectancy in Greece remains lower than that in several other EU countries (such as Italy, Spain and France), where life expectancy exceeds 82 years.[23] Greece is a unitary State and its political system is parliamentary republic, established by the 1975 Constitution (in Greek: Syntagma, henceforth: the Constitution), which is the supreme national law and has been amended three times since its adoption.[24] Importantly, the Constitution provides for the principle of separation of powers under its Article 26

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18 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Dainius Pūras, UN HRC, 29th Sess., Agenda Item 3,* UN Doc. A/HRC/29/33, 2 April 2015, § 40; Another reason to opt for Greece has been of course that the author has easy access to Greek legal system.

19 See generally, e.g., B. Toebes, R. Ferguson, M. Markovic & O. Nnamuchi, *The Right to Health - A Multi-Country Study of Law, Policy and Practice*, The Hague: T.M.C. Asser press/Springer 2014; C.M. Flood & A. Gross, *The Right to Health at the Public/Private Divide: A Global Comparative Study*, Cambridge: Cambridge University Press 2014.

20 Available at <http://europa.eu/about-eu/countries/member-countries/greece/index_en.htm>

21 Ibid.

22 Organization for Economic Cooperation and Development, *OECD Health Statistics 2014*, Paris: OECD <www.oecd.org/health/healthdata>.

23 Ibid.

24 Article 1 § 1 of the Constitution of Greece (1975-1986-2001-2008), as revised by the parliamentary resolution of 27 May 2008 of the VIIIth Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue A′ 120/27-06-2008. The texts of the Constitution of Greece are the Official translation of the Hellenic Parliament available at <www.hellenicparliament.gr>; For an elaborate analysis of the Greece's constitutional history see, K.G. Mavrias & A.M. Pantelis, *Constitutional texts- Greek and Foreign*, Athens - Komotini: Ant. N. Sakkoulas 1981, pp. 7-219.

placed in the section entitled 'Structure of the State'.[25] Accordingly, the legislative powers shall be exercised by the Parliament and the President of the Republic.[26] The executive powers shall be exercised by the President of the Republic and the Government.[27] Lastly, the judicial powers shall be exercised by Courts of Law which are distinguished into administrative, civil and criminal Courts (Art. 93 § 1 of the Greek Constitution) and are organized in three levels of hierarchy (i.e., in three instances): i) the Supreme Courts, which are the highest courts in Greece and encompass the Supreme Civil and Criminal Court (in Greek: Areios Pagos), the Council of State (Supreme Administrative Court, in Greek: Symvoulio tis Epikrateias, StE), the Court of Audit (in Greek: Elegktiko Synedrio), the Supreme Special Court (in Greek: Anotato Eidiko Dikastirio), ii) the Courts of Appeals (higher and appellate Courts) and iii) the Courts of First Instance (lower Courts).[28] Meanwhile, for the purposes of our study it is essential to note that in the section entitled 'Structure of the State' it is also provided that after ratification by statute international treaties as a whole become part of the national legal order and prevail over any contrary provision of the law in Greece.[29] Hence, Greece has a clear constitutional provision stipulating the applicability and status of international treaties *vis-à-vis* national law. International treaties have no direct validity in national law until they are incorporated into the national legal system. As regards the European perspective of Greece, since 1975 Greece actively participates in the European integration process on the basis of Article 28 §§ 2 and 3 of the Constitution within the context of limiting its national sovereignty. Since 1 January 1981, Greece is an EU member State, thereby constituting one of the frontier States of the EU.[30]

Economically speaking, since 2010 Greece is experiencing a severe financial crisis owed to a large budgetary deficit and for that reason has been undergoing major economic restructuring.[31] Being confronted with this hardly manageable

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[25] Ibid.

[26] The legislative procedure involving the Parliament is set out in Articles 70-80 of the Constitution and the President of the Republic in Article 42 of the Constitution.

[27] Of note, legislative and executive powers are interdependent in virtue of Article 26 of the Constitution which provides that both powers shall be exercised by the President of the Republic.

[28] The functioning (organization and jurisdiction) of the judicial power is elucidated in Section V of the Constitution, namely in Articles 87-100A of the Constitution.

[29] Article 28 § 1 of the Constitution.

[30] Greece signed its Treaty of Accession to the EU in 1979 and ratified the EC treaties by Law 945/1979 (*Official Government Gazette* - ΦΕΚ issue Α′ 170/27-07-1979) with a large majority (3/5 of the total number of the members of Parliament) required under Article 28 § 2 of the Constitution.

[31] European Commission, *The Economic Adjustment Programme for Greece,* European

situation, in May 2010 Greece signed a three-year agreement (2010 - June 2013), being renewed in March 2012 for another two years (2012-2014, later extended to the end of June 2015), with a tripartite committee, consisting of the International Monetary Fund, the European Commission and the European Central Bank in order to regain its financial stability (collectively also known as the 'Troika').[32] This agreement is known as the 'Memorandum of Understanding'[33] (MoU) and introduces gradually a variety of austerity measures. Particularly, the implementation of the MoU has significant financial implications on several areas of public services, including the area of health in Greece. One of the most significant measures taken involves the reform of the national health system. Since the signing of the MoU between the Greek State and the tripartite committee, the health sector has been undergoing several changes, primarily including the curtailing of public health expenses and the merger of the public health sector. As regards the costs, in 2012 total health care expenditure in Greece corresponded to 9.3 % of the GDP, equal to the OECD average and lower than that in several other EU countries, such as the Netherlands, Germany and France.[34] As regards the type of funding of health care, in 2012 67% of health expenditure in Greece was funded by public sources, which is below the average of 72% in OECD countries and remains lower than that in a number of EU countries, such as the Netherlands, Germany, Austria and France.[35] Health spending in Greece has reduced in each of the years since the emergence of the economic crisis, especially in both 2010 and 2012 fell by 25% from the level

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Economy - occasional papers No. 61, Brussels: European Commission May 2010; European Commission, *The Second Economic Adjustment Programme for Greece,* European Economy - occasional papers No. 94, Brussels: European Commission March 2012.

32 Ibid.; Note also that given the continuing financial crisis in Greece on 19 August 2015 a third MoU- agreement was signed between Greece and the European Commission acting on behalf of the European Stability Mechanism (ESM), which covers a 3-year period, namely from August 2015 until August 2018 (see, European Commission, *The Third Economic Adjustment Programme for Greece*, Brussels: European Commission August 2015).

33 For a definition on the nature of the MoU, see, e.g., A. Aust, *Handbook of International Law* (2nd ed.), Cambridge: Cambridge University Press 2010, pp. 53-55. Accordingly, the MoU embodies a bilateral or multilateral (operational) agreement which expresses an intended common line of action in most areas of international relations (i.e. trade, aid, defence, finance etc.) between the signatory parties (States and/or international organizations). The MoU often comes into effect on signature, although the legal consequences depend on the circumstances and the terms of each MoU.

34 Ibidem supra note 22.

35 Ibid.

in 2008.[36] In light of the above statistics, it becomes obvious that the total health care expenditure in Greece reaches the OECD average as the Greek citizens pay a relatively high percentage of their income on health compared to citizens of other EU countries, such as the Netherlands and France.[37] Nevertheless, such developments primarily from 2010 onwards concerning the area of health in Greece raise issues of great concern related to health inequalities among the population.[38]

1.2. RESEARCH OBJECTIVES, QUESTIONS AND OUTLINE

This study is directed at discussing the internationally guaranteed right to health mainly from the angle of States obligations and specifically as it occurs within an existing state practice (i.e., the state practice of Greece) in order to bring the highest attainable standard of health closer to reality. The main questions that will be analyzed in this thesis are:

(a) What primary standards derive from the right to health on the basis of human rights law?
(b) Is the right to health being (effectively) implemented in Greece (or not)?

For this reason the present study is organized in two main parts (i.e., Part I & Part II), each dealing with separate research questions and consisting of various chapters. But first, in this introductory chapter, the problem statement and research questions of the study are addressed. Subsequently, in Part I, chapter 2, chapter 3 and chapter 4 are dedicated to analyze the right to health framework, primarily by exploring the normative content of the right to the highest attainable standard of health in human rights law and its implications for the States. In particular, chapter 2 embarks on the task of developing a meaning of the right to health by focusing on*:* 'How is health defined as a right in human rights law in terms of clarifying the ensuing state obligations for its effective realization?' At the core of chapter 2 lies the formulation of health as a right at the international, regional and national level. The discussion of the various documents at the international, regional and national level will offer an insight into the definition of health as a right and the duties of the State, as primary duty holder, to take measures for its effective realization within its jurisdiction. Notably, the provisions enshrining the right to health are primarily directed at the State parties to the various human rights

[36] Ibid.
[37] Ibid.
[38] For concerns on health inequalities in Greece expressed by human rights bodies, see, e.g., UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, §§ 7-8.

instruments and its recognition represents a step in strengthening its enjoyment by every individual. As such, despite the several conflicting views on its nature and various aspects, the internationally guaranteed right to health obligates States to create favorable conditions for the achievement and maintenance of the highest attainable level of health of all human beings. Ultimately, it will be argued that the right to health can be enforced by other rights that address integral components of this right. Thus, the human rights framework providing for the right to health as well as the connection between the right to health and other human rights will be set out in chapter 2.

Subsequently, chapter 3 will answer the question: 'what standards can be identified from the interpretation of the content of the right to health for its effective realization on the part of the State?' Importantly, understanding the content of the right to health imparts an understanding of what steps -implementation measures- are required primarily on the part of the State in order to realize the right to health at a country level. The task of establishing a normative account of the right to health undertaken in chapters 2 and 3 will be supplemented by the analysis followed in chapter 4. Chapter 4 will focus on the realization process of this right on the part of the State primarily on the basis of the work of human rights bodies, by answering the question: 'How are the standards derived from the interpretation of the normative framework of the right to health concerning respective State's obligations informed by the work of human rights bodies?' Chapter 4 shall explore a number of parameters placed around the realization process of the right to health on the part of the State. Focus will be placed on access to health care as a way to achieve the right to health, although, where relevant, reference to the underlying determinants of health will be made. Given the broad range of issues that can potentially be addressed, the study will limit itself to a selection of topics. Therefore, attention is paid to the work of three international monitoring bodies by examining respective reports, of one regional body by exploring the justiciability of the right to health with a focus on Europe as well as to the implications of international co-operation, as a means for ensuring the right to health. The work of these bodies -albeit abstract and haphazard at times- can provide an account of how the right to health framework can be operationalised at national level, namely how this framework can shape the state measures for realizing the right to health for every individual within a State's jurisdiction.

Note that the State is the primary focus of international law when it comes to enforcement and responsibility.[39] This means that the realization of the right to

[39] Ibidem supra note 11.

health is dependent upon each State's commitment to create favorable conditions in line with its capacity (i.e., available resources, budget allocation), cultural values and its translation into operational health policies, programmes and other health-related interventions. Building on the analysis of chapters 2, 3 and 4 of Part I, the next step is to learn about how this norm is operationalised (or not) at a country level in view of particular challenges (i.e., involving economic austerity, health sector privatization and corruption, vulnerable groups etc.). Generally, Part II, consisting of chapters 5, 6, 7 and 8, discusses the right to health within a specific situation. This will be achieved by finding out to what extent Greece recognizes the existence of a right to health and what measures Greece has taken (or not) to ensure its effective realization within its jurisdiction. The research questions here are: 'Does Greece have a commitment to health and is Greece bound by a right to health under international law? If so, (how) has Greece given effect to its binding right to health obligations for securing the health of the population as a whole? Whether the Greek State can afford to accomplish its international commitments? Are certain population groups in Greece being left out and, if so, to what extent?'

Specifically, in chapter 5, the extent to which there is a sense of state responsibility towards the right to health of every individual in the Constitution of Greece (i.e., a State's commitment) will be explored. Additionally, in the subsequent chapters, we will discuss whether this goal (i.e. the State's commitment), with emphasis on particular research topics, has been achieved and if so, we will elucidate its nature within the national context. Note that these research topics are of specific relevance to the country in question and constitute enduring concerns of respective human rights bodies. Thereby, in chapter 6, attention is paid to the advancement of the population's health as a whole in terms of the State's obligation to provide for a health infrastructure (i.e., a National Health System) under the 'AAAQ' requirements, a significant component of the internationally guaranteed right to health.

Subsequently, in chapters 7 and 8 we will go one step further and examine certain vulnerable population groups, namely undocumented (or in an irregular situation/non-documented) migrants and Roma children, whose particular situation is identified and is noted with concern by respective human rights bodies in their reports addressed to Greece. Note that both population groups face primarily a double vulnerability: undocumented migrants as migrants and as persons in an irregular situation; and Roma children as children (i.e., below the age of 18) and as persons belonging to an ethnic minority (i.e., Roma). Specifically, in the respective chapters the position of these groups in Greece in relation to their right to health and access to health care will be discussed. By going through this analysis, Greece's compliance with its respective binding international obligations will be examined.

Finally, chapter 9 will sum up the main findings of the present study and draw a conclusion concerning the prospects for enhanced operationalisation and effective realization of the right to health at the national level. Last but not least, this study is supplemented by two annexes (i.e., Annex 1 & Annex 2) which require a note of explanation. Particularly, Annex 1 in addition to the right to health identifies many other human rights that are significant and connected to health. Moreover, Annex 2 consists of a table involving the ratification of relevant for the case study human rights documents that include a right to health as well as their integration in the respective domestic legal order.

1.3. METHODOLOGY

Part I contains a legal analysis of the relevant international and regional legal documents on health as a right as well as relevant scientific literature. This part of the study is mainly based on official documents of human rights bodies at the UN level and at the regional level (primarily at the European level), on a literature research and a case-law analysis. These sources tend to provide further clarification on the content and realization process of the right to health, namely determine what steps are required on the part of the State to effectively realize the right to health of individuals within its jurisdiction. In particular, Part I is based on a discussion of the relevant legal sources (i.e., treaties, conventions, national constitutional law etc.), documents of UN human rights and European monitoring bodies (i.e., General Comments, Concluding Observations on the Country Reports, Conclusions of the European Committee of Social Rights and Reports etc.) and other sources, including UN Conferences, which provide standards and useful interpretation material for the right to health, primarily the state obligations arising from it. At this point, it is worth bearing in mind that all relevant sources, examined in Part I, are not of equal legal status. Strictly speaking, this means that a treaty carries superior legal weight compared to General Comments and/or documents containing Concluding Observations (i.e., treaty bodies' interpretations and views which do not have binding legal authority *per se* - see sections 2.2.4 & 4.2). In addition, it is important to acknowledge that the scope and legal status of a legal source, for example of a treaty, remains limited when ratifications to this source are scarce (e.g., MWC). On the contrary, when a legal source (treaty) has been ratified by the majority of the countries worldwide (e.g., ICESCR and CRC) this is reflective of the broader recognition of its status and of the great extent of its legal weight (see chapter 2). Clearly, all sources, elaborated in Part I for the interpretation of the various formulations of the right to health and its realization process do not bear the same legal weight.

Understandably, the methodology applied in Part I highly reflects the treaty interpretation methods as laid down in Articles 31 (*'general rule of interpretation'*) and 32 (*'supplementary means of interpretation'* particularly the *travaux préparatoires*) of the Vienna Convention on the Law of Treaties.[40] Indeed, pursuant to Article 31 (1) of the Convention 'a treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose'.[41] In fact, in addition to the text of the treaty, Article 31(2) determines that the 'context' shall include its preamble and annexes, any agreement made between all the parties in connection with the treaty and any instrument made by one or more parties and accepted by the other parties as an instrument related to the treaty.[42] Together with the context, Article 31(3) establishes that any subsequent agreement between the parties regarding the interpretation of the treaty, any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation as well as any relevant rules of international law must also be taken into account.[43]

At the same time, the methodology applied in Part II includes literature research, a study of existing national law, policy and case-law analysis. Moreover, for the purpose of the study of the state practice, that stands central to this part of the study (i.e., Greece's practice), thorough research has been conducted based on existing reports of the WHO, UNICEF, OECD, Frontex, European Union Agency for Fundamental Rights, NGOs (e.g., ERRC, MdM, MSF) etc. An analysis of the extent of harmonization of national law-policy in Greece with international and European standards is included, on the basis of official national texts of laws and policies (e.g., official records of Greek parliament's sessions, reports of the Greek Ombudsman, Ministerial Decisions etc.).

All in all, the sources of information on which this study is based were acquired by means of extensive and detailed (library and digital) research. All but the sources concerning national law-policy are in the English language. This research covers the period between (July) 2010 and (June) 2015 which has been used as a cut-off

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40 Vienna Convention on the Law of Treaties, Vienna 23 May 1969, entry into force 27 January 1980, 1155 UNTS 331. Note also that Vienna Convention generally reflects customary international law (See, e.g., M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, p. 3).

41 Ibid.

42 Ibid.

43 Ibid.

date for considering sources of information; nevertheless, later relevant notable developments have been occasionally included.

Finally, given that the meaning and normative content of the internationally guaranteed right to health are further elucidated (see Part I), I hope that confining Part II to a particular state practice (i.e., the practice of Greece) will help the study gain in depth on how this norm is to be implemented on the part of a State in view of a particular national reality (e.g., economic austerity, health sector privatization and corruption, vulnerable groups and embedded inequalities etc.). Note that, despite the challenge of difference between countries (e.g. size and economic development etc.), the outcomes of the present study on themes many of which exist (to some extent) in every country[44] by facing similar problems may help to formulate, review or fully replace national health policies, laws and focus efforts with the ultimate objective the effective realization of the right to health on the part of States (i.e., positive impacts on the health and well-being of all individuals over the world).

1.4. TERMINOLOGY

As stated previously, this study deals with the formulation of health as a right in human rights law and its operationalisation at the national level through the examination of national laws and implementation measures of a certain country, Greece. Accordingly, this study uses the term 'right to health', as its use may be more appropriate and therefore potentially useful when it comes to define health as a right due to its multi dimension, even though in literature there is little consensus on the terminology of this right (see Part I, chapter 3).[45] Importantly, the term 'right to health' embraces the following dimensions: access to health care and underlying determinants of health, such as access to clean drinking water and food, adequate housing and living conditions, health promotion as well as specific state responsibilities to secure the health of individuals. Notably, this term reflects the broad notion of health as a right found in the WHO Constitution as well as embedded in Article 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR, 1966), which embraces a wide range of measures to be

[44] Ibidem supra note 19.

[45] As regards various arguments on the terminology of the right to health, see, e.g., V.A. Leary, 'The Right to Health in International Human Rights Law' *Health and Human Rights* 1994, 1, 1, pp. 25-56, pp. 28-31(citing relevant studies); See, Chapter 3 for an understanding of the distinctive features and meaning of health as a right.

taken by States, covering not only access to health care, but also access to the underlying conditions for health.[46]

Other terms used to define health as a right, involve 'the right to health care' and 'the right to protection of health' (see Part I, chapter 2), which in literature are considered to be more realistic and workable terms than the broadly-based term 'right to health'.[47] Notably, the (Revised) European Social Charter (ESC) employs the term 'protection of health' (Article 11) instead of using the terms 'right to health' or 'right to the enjoyment of health'. The use of the term 'protection' embraces positive state obligations to take measures with a view to ensuring the *effective exercise of the right to protection of health.* This means that States must bear responsibility in ensuring improvement of public health; availability and access to health care; fair distribution of the social determinants of health; and adoption of preventive and educational measures to protect the health of individuals.[48] In this sense, the Charter of Fundamental Rights of the European Union (CFREU) also uses the term 'human health protection' in its Article 35 (see Part I, section 2.3). Note that this term encompasses an entitlement to (preventive and curative) health care, while at the same time it gives rise to a corresponding duty within all Union policies and activities.[49] Likewise, the Treaty on the Functioning of the European Union (TFEU) employs the term 'human health protection' in its new Article 168 (former Article 152 TEC) and requires that human health is protected in all Union policies and activities.[50] This means that the EU is under the obligation to co-operate and work with EU Member States towards improving public health, preventing illness and diseases, removing sources of danger to physical and mental health.[51] On the basis of the respective provision human health protection is, thereby, a treaty obligation. Meanwhile, the scope of

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46 Ibidem supra note 6, GC No. 14, § 11.

47 See e.g., B. Toebes, Towards an Improved Understanding of the International Human Right to Health, *Human Rights Quarterly* 1999, Volume 21, pp. 661-679, p. 662 (citing relevant studies); Ibidem supra note 45, V.A. Leary 1994.

48 European Social Charter 1961(Revised), adopted on 3 May 1996, entered into force on 1 July 1999, 2151 UNTS 277, ETS 163; See also, The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC, March 2009.

49 Charter of Fundamental Rights of the European Union, Doc. 2000/C 364/01, available at: <http://www.europarl.europa.eu/charter/pdf/text_en.pdf>

50 Consolidated Version of the Treaty of on the Functioning of the European Union, *Official Journal of the European Union*, 26 October 2012, Doc. 2012/C 326/47. Available at <www.eur-lex.europa.eu>

51 Ibid., Article 168 § 1.

the content of the term 'to protect' is rather limited.[52] In particular, the obligation to protect constitutes one of the three different types of obligations imposed on States parties in order to implement the right to health at the national level. In terms of the obligation *to protect* States are required to take all necessary measures to prevent third parties from the infringement of the right to health (see Part I, section 3.3).[53]

[52] See, e.g., B.C.A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp/Oxford: Intersentia/Hart 1999, p. 20.

[53] Ibidem supra note 6, § 33.

PART I

FROM THEORY TO PRACTICE

2 The Right to Health in Human Rights Law and its Connection to other Human Rights

2.1. INTRODUCTION

However phrased and although there are scholars who hold diverse views on its nature and scope, health as a right is recognised worldwide.[1] International and regional human rights regulations define health as a right as well as impose a range of obligations on States parties for the fulfillment of this right. The formulation of a right to health in various human rights documents is of importance in that it can contribute to an understanding of the normative framework of the respective right and of the nature of state measures required for realizing this right. As such, Chapter 2 draws attention to key formulations of the right to health adopted in human rights law and its relation to other human rights. Chapter 2 is primarily divided into three sections, namely the international, regional and national, and examines key instruments that add substance to the content of the right to health. In particular, after an analysis of the key formulations and sources of the right to health in international law in section 2.2, regional instruments in Europe that lay down a right to health will be discussed. In addition, section 2.4 addresses the right to health as it appears in national context, namely in national constitutional law. Finally, in section 2.5 the connection of the right to health to other human rights will be identified.

2.2. HEALTH AS A RIGHT AT THE INTERNATIONAL LEVEL

Given the significance of health as a vital feature of the human condition (see section 1.1), health has been recognised as a right in numerous international documents (see below sections). For instance, at UN level, the World Health Organisation (WHO) has observed that every country in the world is a party to at

[1] See, e.g., V.A. Leary, 'The right to health in international human rights law', *Health and Human Rights* 1994, Volume 1, Number 1, pp. 25-56, p. 26; T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, Volume 30, Issue 3, pp. 643-662.

least one human rights treaty that deals with health-related rights, including the right to health.[2] In line with this statement of WHO, Navanethem Pillay, the former UN High Commissioner for Human Rights, underlines that 'the right to health is a fundamental part of our human rights'.[3] This argument has been also defended by academics. Lawrence O. Gostin, for example, considers the right to health as 'perhaps the most important social and economic entitlement'[4]. Similarly, John Harrington and Maria Stuttaford point out that 'the human right to health has moved to the centre of political debate and social policy across the globe'.[5] Meanwhile, there are scholars who have been critical of the right to health and its various aspects. For instance, Jennifer Prah Ruger holds the view that 'one would be hard pressed to find a more controversial or nebulous human right than the 'right to health'.[6] Therefore, the following analysis will be confined to an outline of the key international formulations of health as a right in an effort to reveal its various expressions as well as to elucidate the key features of this right in international law and the state obligations that derive from this legal framework. Hereto, the international documents that will be examined include, *inter alia*, the WHO Constitution, the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) as well as other UN conventions relating to specific population groups.

2.2.1. WHO CONSTITUTION, UDHR & ICESCR

1 The WHO Constitution

In 1946, the World Health Organization adopted the first right to health provision worldwide in the preamble of its Constitution.[7] In particular, States declared that

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2 WHO, *25 Questions and Answers on Health & Human Rights*, Health & Human Rights Publication Series, Issue No. 1, Geneva: World Health Organization 2002, p. 12.

3 N. Pillay, 'Right to health and the Universal Declaration of Human Rights' *Lancet* 2008, Volume 372, Issue 9655, pp. 2005-2006.

4 L.O. Gostin, 'The Human Right to Health: A Right to the "Highest Attainable Standard of Health' *Hastings Centre Report* 2001, Volume 31, Issue 2, pp. 29-30, p. 29.

5 J. Harrington & M. Stuttaford, 'Introduction' in: J. Harrington & M. Stuttaford (eds) *Global Health and Human Rights: Legal and Philosophical Perspective*, London: Routledge 2010, pp. 1-11, p. 1.

6 J.P. Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' *Yale Journal of Law & the Humanities* 2006, Volume 18, Issue 2, pp. 273-326, p. 273; J.P. Ruger, *Health and Social Justice*, Oxford: Oxford University Press 2010, p. 119 (citing relevant studies).

7 The WHO Constitution was adopted by the International Health Conference held in New

'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition'[8], defining health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[9] In conjunction with the definition of health as a right, the preamble to the Constitution underlines, *inter alia*, the connection between unequal development of States and the promotion of health and control of (communicable) diseases; the significance of the healthy development of the child as well as of health-related knowledge of individuals, of informed opinion and active co-operation of the public for the improvement of their health.[10] The WHO definition of the right to health was influential in articulating the right to health language included in various international human rights treaty provisions.[11]

In literature, it is pointedly argued that WHO by expressly including the mental and social dimensions of well-being adopted an expansive definition of health and therefore extended the roles and duties of health professionals and their relation to the society at large.[12] Such a definition, though encapsulates the dimensions of the conditions of health (i.e., physical, mental and social)[13], has received criticism as being too broad for law and policy making, in that it likely provides no useful tool to make this right operational, namely a reasonable and workable standard to judge the health of an individual and/or a population.[14] As such, one may agree with the position that this right as defined by WHO is simply not practical and

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York, from 19 to 22 July 1946, signed by the representatives of sixty-one States on 22 July 1946, two years before the UDHR was proclaimed, (Official Records of the World Health Organization, 2, 100), and entered into force on 7 April 1948.

8 Ibid., Preamble to the Constitution.

9 Ibid.

10 Ibid.

11 B.C.A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp/Oxford: Intersentia/Hart 1999, p. 36.

12 J.M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini & H. Fineberg, 'Health and Human Rights', in: J.M. Mann, S. Gruskin, M.A. Grodin & G.J. Annas (eds.), *Health and Human Rights: A Reader*, New York/London: Routledge 1999, pp. 7-20, p. 8.

13 See also, earlier scholars, e.g., H.E. Sigerist, *Medicine and Human Welfare*, New Haven/London: Yale University Press/Oxford University Press 1941, p. 100; See also, section 3.2.

14 See, e.g., J.P. Ruger, *Health and Social Justice*, Oxford: Oxford University Press 2010, p. 122; Ibidem supra note 11, pp. 23 and 32-36; E.D. Kinney & B. Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' *Cornell International Law Journal* 2004, Issue 37, pp. 285-355, p. 289; Ibidem supra note 4, L.O. Gostin 2001, p. 29.

realistic when it comes to be applied, because of its high level of abstraction as to its content. Indeed, in practice, this argument is advocated well if one considers that WHO has partly failed to mainstream the broad-based right to health in its own health policies and programmes[15], with the exception its 2005 International Health Regulations (see section 2.2.3) which seem to offer an international legal approach to health.

2 ARTICLE 25 § 1 UDHR

Early in the history of the UN, the Universal Declaration of Human Rights (UDHR) was adopted by the UN General Assembly in 1948.[16] The UDHR acknowledges health as a right in Article 25 § 1 differently than the WHO Constitution. Particularly, Article 25 § 1 provides that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control'.[17]

The final wording of the UDHR -Article 25-, which was the result of many debates and several proposed drafts by the drafting committee, was adopted with only minor amendments by the General Assembly.[18] The right to health as such is not incorporated in the text of the respective provision of the UDHR. On the contrary, the UDHR includes in its Article 25 § 1 health indirectly and broadly, as being integral component of the right to an adequate standard of living. This article stipulates a general entitlement to an adequate standard of living, by way of recognizing -albeit at an abstract level- guarantees for health and well-being as well as a link to other rights, such as the rights to food and housing.[19] As such, this provision alludes that the enjoyment of the right to an adequate standard of living

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15 See for a critical view of WHO policies, e.g., B.M. Meier, 'The World Health Organization, the evolution of human rights, and the failure to achieve Health for All' in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 163-183.

16 See, J. Morsink, *The Universal Declaration of Human Rights: Origins, Drafting and Intent*, Philadelphia: University of Pennsylvania Press 1999. Note by way of background that 48 States voted in favor and 8 States abstained (p. 21).

17 UDHR, adopted on 10 December 1948, by G.A. Res. 217A (III), UN Doc. A/810.

18 Ibidem supra note 16.

19 A. Eide & W. Barth Eide, 'Article 25', in: G. Alfredsson & A. Eide (eds.), *The Universal Declaration of Human Rights: A Common Standard of Achievement*, The Hague/Boston/London: Martinus Nijhoff publishers 1999, pp. 523-550, pp. 523-524.

requires, as a minimum, that every individual shall enjoy the necessary rights, such as adequate food, clothing, housing and the necessary conditions of medical care.[20]

Importantly, the UDHR does not impose legally binding obligations on States. Even so, the UDHR has been regarded as the cornerstone of the human rights movement. Some commentators argue that the UDHR is not a 'mere' statement of principle, but it has obtained growing legal force through customary law.[21] Henry Steiner, for example, notes that 'No other document has so caught the historical moment, achieved the same moral and rhetorical force, or exerted as much influence on the movement as a whole (…) bore a more radical message than many of its framers perhaps recognised … proceeded to work its subversive path though many rooted doctrines of international law, forever changing the discourse of international relations on issues vital to human decency and peace.'[22]

Nonetheless, not being the UDHR a legal document involving legal state obligations, the UN adopted two Covenants to elaborate its provisions and transform them in legally binding norms. These Covenants were the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These human rights instruments together with the UDHR are known as the International Bill of Human Rights.[23] Interestingly, in literature, it is argued that the decision to draft two separate Covenants, namely the ICCPR and the ICESCR, was, *inter alia*, a reflection of the unwillingness of some western States to be parties to a single Covenant covering both CP rights and ESC rights, primarily on the basis of implementation reasons.[24]

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20 Ibid.

21 P.G. Lauren, *The Evolution of International Human Rights: Visions Seen* (2nd ed.), Philadelphia: University of Pennsylvania Press 2003, p. 232; H. Hannum, 'The Status and Future of the Customary International Law of Human Rights: The Status of the Universal Declaration of Human Rights in National and International Law', *Georgia Journal of International and Comparative Law* 1995, Volume 25, Number 2, pp. 287-398; H.P. Hestermeyer, 'Access to Medication as a Human Right', in: Ar. Von Bogdandy & R. Wolfrum (ed.), *Max Planck Yearbook of United Nations Law* Volume 8, Leiden: Martinus Nijhoff Publishers 2004, pp. 101-180, p. 156.

22 H.J. Steiner, P. Alston, & R. Goodman, *International Human Rights in Context- Law, Politics and Morals* (3rd ed.) Oxford: Oxford University Press 2008, p. 136.

23 M.A. Baderin & R. McCorquodale, 'The International Covenant on Economic, Social and Cultural Rights: Forty Years of Development', in: M.A. Baderin & R. McCorquodale (eds.), *Economic, Social and Cultural Rights in Action*, Oxford: Oxford University Press 2007, pp. 3-26, pp. 4-9.

24 Ibid.; See, e.g., A. Eide, 'Economic, Social and Cultural Rights as Human Rights', in: A. Eide, C. Krause and A. Rosas (eds) *Economic, Social and Cultural Rights: A Textbook,* 2nd

3 Article 12 ICESCR

Despite the objections to the legally binding nature and meaning of economic and social rights found in literature[25], the ICESCR (1966) is the first international legal source of ESC rights that recognizes the right to health under Article 12.[26] In fact, Article 12 ICESCR adopts the affirmative definition of health (i.e., *the highest attainable standard of physical and mental health*) and the enumeration of exemplary steps required by States parties for realizing the right to health within their jurisdiction.[27] Nonetheless, Article 12 ICESCR (initially Article 13, eventually Article 12) was subjected to several changes until its final adoption by the UN General Assembly.[28] Indeed, the first paragraph of the Article under discussion initially provided that 'the States parties to the Covenant, realizing that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, recognize the right of everyone to the enjoyment of the highest attainable standard of health'.[29] However, the General Assembly's Third Committee decided not to include this definition of health into the final text,

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Ed., Dordrecht/ Boston/London: Martinus Nijhoff Publishers 2001, pp. 9-28, pp. 10-11; Of note, as it goes well beyond the scope of this chapter to elaborate on this issue, for a discussion concerning conflicting arguments during the drafting process lasting nearly twenty years (1949-1966), see Annotations to the Text of the Draft International Covenant on Human Rights, UN Doc. A/2929, 1 July 1955, Ch. II, p. 7; M. Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Antwerp: Intersentia 2003, pp. 116-118 (citing relevant studies).

25 As regards to the objections expressed in literature, see, e.g., M. Scheinin, 'Economic and Social Rights as Legal Rights' in: A. Eide, C. Krause & A. Rosas (eds.) *Economic, Social and Cultural Rights: A Textbook*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 2001, pp. 29-54, pp. 29-31(citing relevant studies); M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, pp. 352-353.

26 International Covenant on Economic, Social and Cultural Rights (ICESCR) 16 December 1966, entered into force 3 January 1976, 993 UNTS 3. As at 30 June 2016, 164 States were parties to the ICESCR (among which Greece – see Annex 2) and as such the ICESCR holds almost universal ratification; See, e.g., S. Leckie & A. Gallagher, *Economic, Social and Cultural Rights: A Legal Resource Guide*, Philadelphia: University of Pennsylvania Press 2006, p. xiv and pp. 5-14; Ibidem supra note 2, p. 9.

27 Ibid.

28 Ibidem supra note 11, B.C.A. Toebes 1999, pp. 41-52 (provides an overview of the drafting history of the right to health in the ICESCR).

29 Ibid.; See also, *Annotations on the text of the draft International Covenants on Human Rights,* UN Doc. A/2929, 1 July 1955, Ch. VIII, p. 111.

due to disagreement.[30] As such, the final wording of Article 12 § 1 ICESCR provides that: 'States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[31] Apart from the reference to physical and mental health, the term 'health' is not further defined. There is no explicit reference to social well-being in ICESCR such as is found in the WHO definition. Note also that the implementation nature of Article 12 § 1 ICESCR is qualified by the general approach of the ICESCR embedded in its Article 2 § 1. Simply put, States parties are obliged to progressively realize the right to health to the maximum of their available resources (see sections 3.4 and 4.2.1).[32]

Another matter of dispute during the drafting of Article 12 ICESCR was whether or not to specify in the text steps required by States for realizing the right to health. Some participants argued that there was no need to make a reference to definite steps in the text, whereas others were in favor of using an explicit and concrete language as to the state obligations arising from the right to health.[33] Hence, the final wording of Article 12 § 2 ICESCR sets out, in a non-exhaustive way, a list of four specific areas in which States are required to take steps in order to achieve the full realization of this right. This list includes: (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.[34] The above steps generally illustrate that the right to health is not only curative and preventive, but also requires the enhancement of conditions that promote the health of individuals. All in all, this exemplary enumeration of steps indicates the obligations of the States -the primary duty holders-, towards the individual-the rights holder.

Nonetheless, altogether these state obligations under Article 12 ICESCR read in conjunction with Article 2 § 1 ICESCR broadly formulate the right to health, in that not only they do not concretely define its meaning and its particular elements, but also they do not include an exhaustive enumeration of principal conditions

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30 Ibid., §§ 33 & 34 (Art.13).

31 Ibidem supra note 26.

32 Ibidem supra note 26, Article 2 § 1 ICESCR.

33 Ibidem supra note 29, § 35(Art.13); See generally, H.D.C. Roscam Abbing, *International Organizations in Europe and the right to health care*, Deventer: Kluwer 1979, pp. 64-77; Ibidem supra note 11, pp. 41-52.

34 Ibidem supra note 26.

required by States for its enjoyment by every individual. Given the lack of clarity about the scope of the right to health and the nature of the ensuing state obligations several objections as to its formulation under Article 12 ICESCR have been expressed by academic commentators. For example, generally speaking of the ICESCR Craven opined that the rights recognised in the Covenant 'are stated in an excessively broad and general manner'.[35] Meanwhile, more specifically in literature it is maintained that the right to health as enshrined in Article 12 ICESCR has been misconstrued as an aspirational rather than an enforceable individual right.[36] Thereto, the view taken here is that given also the high level of abstraction that characterizes Article 12 ICESCR, an interpretation must be attempted by other sources in order to achieve clarity as to the content of the right to health. As will be mentioned below, an authoritative -albeit expansive- interpretation of the meaning of the broad-based right to health in Article 12 ICESCR and of the nature of the ensuing state obligations is provided by the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment (GC) No. 14 (see section 2.2.4 and chapter 3).[37]

2.2.2. OTHER UN TREATIES

Over the years a number of other subsequent UN legally binding human rights documents have focused on the right to health of specific populations groups, including children, women, racial minorities, migrant workers and persons with disabilities. Such treaties include the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), the International Convention on the Elimination of All forms of Racial Discrimination (ICERD), the International Convention on the Protection of the

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[35] Ibidem supra note 25, M.C.R. Craven 1995, p. 353.

[36] See, e.g., L. Forman, 'What future for the minimum core? Contextualizing the implications of South African socioeconomic rights jurisprudence for the international human rights to health' in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 62-80, p. 66; T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, Volume 30, Issue 6, pp. 643-662; Ibidem supra note 25, M. Scheinin 2001 (citing relevant studies).

[37] UN CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E./C.12/2000/4, 11 August 2000; Note also that as regards to the right to sexual and reproductive health, an integral component of the right to health (§1), the CESCR has adopted General Comment No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016.

Rights of All Migrant Workers and Members of Their Families (MWC) and the Convention on the Rights of Persons with Disabilities (CRPD). Each of these conventions expanded the human rights protection applicable to these specific groups beyond those offered under ICCPR and ICESCR. Additionally, each aforementioned convention aims to contribute to the normative development of human rights, in general and the right to health *in concreto* within its specific contexts by defining and expanding the contours of these rights (see below).

1 Article 24 CRC

The CRC (1989) under Article 24 stipulates the right to health of the child. In particular, Article 24 § 1 CRC provides that 'States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.'[38] As such, Article 24 § 1 CRC entails entitlements to both health care and the underlying determinants of health. By way of background, it is noteworthy that when looking at the *travaux préparatoires* of the CRC, it is discerned that the wording of the phrase *'*the enjoyment of the highest attainable standard of health' in Article 24 § 1 was inspired by the language of Article 12 § 1 ICESCR.[39] It can also be observed that the specific reference of the provision 'to facilities for the treatment of illness and rehabilitation of health'*,* which is also found in Article 23 CRC (disabled children), is in conformity with the policies of the WHO.[40] Furthermore, under Article 24 § 1 States parties have an obligation 'to ensure that no child is deprived of his or her right of access to such health care services'.[41] Meanwhile, it appears that the wording of this provision, namely the inclusion of the term 'no child is deprived', imposes a relatively strong state duty in that it requires health care to be available and accessible to all children.[42] During the

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[38] Convention on the Rights of the Child, New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3. As at 30 June 2016, 196 States were parties to the CRC among which Greece (see Annex 2).

[39] S. Detrick (ed.), *The United Nations Convention on the Rights of the Child. A Guide to the "Travaux Préparatoires"*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 1992, pp. 343-359; S. Detrick, *A Commentary on the United Nations Convention on the rights of the child,* The Hague: Kluwer Law International and Martinus Nijhoff Publishers 1999, p. 402.

[40] Ibid., S. Detrick 1999, pp. 399 & 404.

[41] Ibidem supra note 38.

[42] A. Eide & W. Barth Eide, 'Article 24. The Right to Health' in: A. Alen, J. Vande Lanotte,

course of the drafting of Article 24 the term 'no child shall be deprived of his or her right of such health care facilities' was decided as a compromise between conflicting views on whether State parties should be required to provide health care free of charge.[43]

The second paragraph of Article 24 CRC contains a number of broad-based measures with a main focus on health care that States should take with a view to pursuing the full implementation of the right to health of the child. Particularly, such measures include the reduction of infant and child mortality (2-a), the provision of necessary medical assistance and health care for all children with an emphasis on primary health care (2-b), pre- and post-natal health care for mothers (2-d), to combat disease and malnutrition, including within the framework of primary healthcare (2-c), to enable children and their families to have access to education, basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene, environmental sanitation, prevention of accidents (2-e) and preventive health care, family planning education (2-f). Further, Article 24 § 3 obligates States 'to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children'.[44] Moreover, Article 24 § 4 places an emphasis on the role of international co-operation in relation to the right to health of the child by encouraging States to engage in such co-operation with a view to progressively realize the right.[45]

The list of measures required by States parties under Article 24 § 2 is in some cases similar to that imposed under Article 12 § 2 ICESCR, such as the reduction of infant mortality, whereas in other cases Article 24 § 2 CRC advances the state measures under Article 12 § 2 ICESCR. Areas such as access to health-related information, education and family planning that are adopted in Article 24 § 2 CRC are not addressed under Article 12 § 2 ICESCR (see section 2.2.1). Additionally, Article 24 § 2, § 3 and § 4 CRC contains a number of new provisions, namely, the provision on traditional practices prejudicial to the health of children and the provision of primary health care and facilities for the rehabilitation of health, which highly reflect the policies of WHO, as well as the need for international co-operation for realizing the right to health.[46] On the basis of the above, we may conclude that

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E. Verhellen, F. Ang, E. Berghmans & M. Verheyde (eds.), *A Commentary on the United Nations Convention on the Rights of the Child*, Leiden: Martinus Nijhoff Publishers 2006, p. 11.

43 Ibid., p. 12; Ibidem supra note 39, S. Detrick 1999, p. 403.

44 Ibidem supra note 38, Article 24 § 3 CRC.

45 Ibidem supra note 38.

46 Ibidem supra note 39, S. Detrick 1999, pp. 399 & 404-406; Of note, the primary health

Article 24 CRC provides a more detailed and comprehensive provision than Article 12 ICESCR and as such Article 24 CRC can offer more protection to children than Article 12 ICESCR. Last but not least, it is notable that the implementation nature of Article 24 CRC is informed by the broad obligation embedded in Article 4 CRC, namely the state obligation to take 'all appropriate measures' to the maximum extent of a State's available resources (see section 4.2.2).

In literature, meanwhile, Article 24 CRC has been described as the most specific and expansive provision on the right to health in international human rights law.[47] For example, for Fox and Young[48], Article 24 CRC is international law's 'most elaborate and specific such guarantee'. On the other hand, there are scholars who hold different views as to the formulation of the right to health under Article 24 CRC. It is maintained, for instance, that altogether the state obligations under Article 24 CRC provide a broad framework of measures that requires further interpretation when it comes to be applied worldwide given the different levels of development and children's health needs among countries.[49] Indeed, the wording of Article 24 CRC is rather general in nature and needs to be qualified in practice when interpreted and applied. Thereto, this interpretation must result to the provision of clarity as to the nature of the right to health of children and the associated state obligations under Article 24 CRC, while at the same time it must be cognizant of the realities of daily lives of children and their families.[50] As will be mentioned in section 2.2.4, an elaboration of the meaning of right to health of the child

approach was defined in the Declaration of Alma-Ata and reinforced by the World Health Assembly (Doc. A62/8); Note that the concept of primary health care was also embraced in the articulation of the right to health in Article 10 (2) (a) of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (see section 2.3.2) and in Article 14 (2) (b) of the African Charter on the Rights and Welfare of the Child (see section 2.3.3).

47 Ibidem supra note 39, S. Detrick 1999, p. 399; See, e.g., J.E. Doek, 'Children and Their Right to Enjoy Health: A Brief Report on the Monitoring Activities of the Committee on the Rights of the Child', *Health and Human Rights*, 5(2), pp. 155-162, p. 156; E.D. Kinney, 'The Human Right to Health Care' *Rutgers Law Review* 2008, Volume 60, Issue 2, pp. 335-379.

48 S.J. Fox & D. Young 'International Protection of Children's Right to Health: the Medical Screening of Newborns', *Boston College Third World Law Journal* 1991*,* Volume 11, Issue 1, pp. 1-43, p. 42.

49 See, e.g., S.I. Spronk-van der Meer, *The Right to Health of the Child: An Analytical Exploration of the International Normative Framework*, Antwerp: Intersentia 2014, pp. 44-46 (citing relevant studies).

50 Ibid.

enshrined in Article 24 CRC is provided by the Committee on the Rights of the Child (CRC Committee) in its General Comment (GC) No. 15.[51]

2 Article 12 CEDAW

The CEDAW (1979) under respective provisions pays particular attention to women's health and well-being. States parties under Article 12 CEDAW are required to '(1) … take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to *family planning*. (2) … ensure to women appropriate services in connection with *pregnancy, confinement and the post-natal period*, granting free services where necessary, as well as *adequate nutrition during pregnancy and lactation*' [emphasis added].[52] CEDAW in Article 12 § 1 does not mandate States parties to ensure equal access to health care services for women at a relatively general and abstract level, but rather particularly points out that 'health care services' encompass those related to family planning.[53] Moreover, Article 12 § 1 guarantees access to health care services by taking into account at the same time the prohibition against discrimination, while Article 12 § 2 considers women's right to health from a gender perspective by relating this right to maternal health care.[54] As such, it must be recognized that this provision tends to offer some specific content to the notion of the right to health of women.

Meanwhile, Article 12 CEDAW should be read in conjunction with General Recommendation No. 24, adopted by the CEDAW Committee in 1999. Although this document is not legally binding, it is an authoritative source that tends to provide further clarification with respect to state obligations under Article 12 CEDAW and address measures to eliminate discrimination against women with a view to realizing the right of women to health. Accordingly, States are required to eliminate discrimination against women in their access to healthcare services,

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[51] UN CRC Committee, General Comment No. 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, UN Doc. CRC/C/GC/15, March 2013.

[52] CEDAW, adopted by G.A. Resolution 34/180 of 18 December 1979, entered into force 3 September 1981, UN Doc. A/34/46. As at 30 June 2016, 189 States were parties to the CEDAW, among which Greece (see Annex 2).

[53] Ibidem supra note 11, B.C.A. Toebes 1999, pp. 52-55 (provides a brief overview of the drafting history of the right to health in the CEDAW).

[54] See generally, A. Hendriks, 'The Right to Health. Promotion and Protection of Women's Right to Sexual and Reproductive Health under International Law: The Economic Covenant and the Women's Convention' *The American University Law Review* 1995, Volume 44, pp. 1123-1144.

throughout the life cycle, specifically in the areas of family planning, pregnancy, confinement and during the post-natal period.[55] In particular, the measures required by States encompass not only the provision of equal access to quality healthcare for women, but also the respect for confidentiality and for informed consent, the provision of proper health information and health education (information and counselling on family planning).[56] Nevertheless, the CEDAW Committee in its General Recommendation No. 24 does not further elaborate on the meaning of the state obligation to grant 'free services where necessary' by way of identifying the circumstances under which this obligation must be satisfied. Instead, the Committee adopts in its Recommendation a broad position by stating that 'it is the duty of States parties to ensure women's right to *safe motherhood and emergency obstetric services* and they should allocate to these services the *maximum extent of available resources'* [emphasis added].[57]

In the spirit of Article 12 CEDAW, it is worth noting that Articles 14 § 2 (b) and 10 (h) of the Convention also stipulate that States are required to ensure to women on the basis of equality between men and women the right to access 'adequate health care facilities, including information, counseling and services in family planning' and 'specific educational information to help ensure the health and well-being of families' respectively.[58] Additionally, it is notable that Article 11 § 1 (f) of the Convention provides in the context of employment for 'the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction'.[59] Here, the Convention employs a new term 'protection of health' contrary to the wording of other international documents, such as Articles 12 ICESCR and 24 CRC which use the term 'the right to the enjoyment of the highest attainable standard of health'. The use of the term 'protection' alludes to certain undertakings on the part of the States for creating good health conditions for women or at least refraining from acts or omissions detrimental to women's health (see section 3.3).[60]

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55 UN CEDAW Committee, *General Recommendation No. 24: Women and Health*, UN Doc. A/54/38 1999, § 2.

56 Ibid., § 12(d), 20, 22 & 23.

57 Ibid., § 27.

58 Ibidem supra note 52.

59 Ibid.

60 For a definition of the term 'health protection', see, e.g., World Health Organization, Glossary of Terms, Geneva: WHO 1984, § 30. < http://www.who.int>; Ibidem supra note 11, B.C.A. Toebes 1999, p. 247; A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, 5, pp. 389-408, p. 394.

Last but not least, in literature it has been commented that 'given the importance the Women's Convention attaches to nondiscrimination and the elimination of female stereotyped roles, it is easier to understand the inherent meaning of Article 12'.[61] This seems to be true. On the other hand, we should also point out that this is not to suggest that the CEDAW has a limited scope, in that the Convention solely focuses on the principles of non-discrimination and equality without setting forth any health-related state obligation. Instead, the CEDAW primarily under Article 12 requires the adjustment (i.e., incorporation) of these principles in order to eradicate and prohibit gender discrimination both in and outside the healthcare sector. Nonetheless, Article 12 CEDAW has a more limited scope than Article 12 ICESCR, which also includes access to the underlying determinants of health, such as adequate nutrition, sanitation, housing, etc. Toebes, for instance, pointedly argues that this must be viewed as the drafters' intention to focus only on those health-related areas where women require additional protection.[62]

3 Article 5(e)(iv) ICERD

In general, the ICERD[63] (1965) strengthens the non-discrimination and equality principles with respect to race. In particular, Article 5 ICERD contains a specific list of rights, among which the right to health, in which discrimination is not allowed. The ICERD expressed the right to health in Article 5 (e)(iv) in the sense that State Parties are to prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security and social services. As such, under this Article the reference to health as a right is limited only to services and actions related to the elimination of discrimination in relation to public health rather than to the right to health as formulated in Article 12 ICESCR.[64]

Indeed, the precise nature of the obligation under Article 5 ICERD is pointedly

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61 Ibidem supra note 54, A. Hendriks 1995, p. 1141.

62 Ibidem supra note 11, B.C.A. Toebes 1999, p. 55.

63 ICERD, GA Resolution 2106 (XX) of 21 December 1965, entered into force 4 January 1969, 660 UNTS 195. As at 30 June 2016, 177 States were parties to the ICERD, among which Greece (see Annex 2).

64 See, also, UN CERD, General Recommendation No. 20 on Article 5, March 1996, UN Doc. A/51/18, annex VIII, reprinted UN Doc. HRI/GEN/1/Rev.6 (2003), § 1. The Committee observes that Article 5 'apart from requiring a guarantee that the exercise of human rights shall be free from racial discrimination, does not itself create civil, political, economic, social or cultural rights, but assumes the existence and recognition of these rights. The Convention obliges States to prohibit and eliminate racial discrimination in the enjoyment of such human rights'.

acknowledged in the Initial Report to the CERD submitted by the United States of America (USA). The USA maintained the position that Article 5 ICERD does not lay down any substantive health-related state obligation, rather focuses on eliminating discrimination in all its forms.[65] In particular, the respective State stressed that 'article 5 does not affirmatively require States Parties to provide or to ensure observance of each of the listed rights themselves, but rather to prohibit discrimination in the enjoyment of those rights to the extent they are provided by domestic law'.[66]

4 Articles 28, 43 and 45 MWC

Contrary to other international documents (e.g., Article 12 ICESCR), the MWC (1990) contains state obligations solely in the area of access to health care for both documented and non-documented migrant workers and the members of their families under respective provisions.[67] In particular, Articles 28, 43 and 45 MWC grant an equal right to healthcare services to documented migrant workers and the members of their families. Nevertheless, Article 28 is also dedicated to protecting non-documented migrants and their families from discrimination in accessing health care services and facilities. Specifically, Article 28 clearly underlines the right to equal treatment with regard to access to health services for non-documented migrant workers and members of their families in terms only of emergency medical treatment. Although MWC seems to be the only international Convention explicitly guaranteeing a right to medical assistance to non-documented migrants, it does however ensure access to health care for non-documented migrants in a restrictive manner. Put simply, besides access to emergency medical treatment, it does not cover access to other forms of medical treatment (e.g., preventive care, reproductive care etc.) for this population group.

Last but not least, it should be noted that the scope of the Convention is limited, as the number of ratifications to this Convention is still relatively slow. This Convention has still not been ratified by the Member States of the EU, such as

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65 Initial Report of the United States of America to the Committee on the Elimination of Racial Discrimination, UN Doc CERD/C/351/Add.1, 10 October 2000, § 297.

66 Ibid., § 298.

67 MWC, adopted in New York, 18 December 1990, entered into force 1 July 2003, 2220 UNTS 3; Article 5 MWC defines the terms documented (or in a regular situation) and non-documented (or in an irregular situation) migrants workers on the basis of whether or not these individuals obtain an authorization to enter, to stay or to engage in a remunerated activity in the State of employment pursuant to the law of that State and to international agreements to which it is a party.

Greece, as well as by the majority of the countries worldwide.[68] Considering the slow ratification of the MWC, one may agree with the argument that this reflects 'a broader general resistance to recognition of application of human rights standards to migrants, particularly undocumented migrants'.[69]

5 Article 25 CRPD

Article 25 CRPD (2006) recognizes the right of persons with disabilities to 'the enjoyment of the highest attainable standard of health without discrimination on the basis of disability…' as well as imposes on States parties specific obligations in order to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.[70] In other words, the CRPD under Article 25 highlights the significance of the enjoyment of the right to health on an equal basis and without discrimination on the grounds of disability. In particular, under Article 25 (2), States are required to provide access to health services on an equal basis with others, including in the area of sexual and reproductive health and public health programmes (2-a), to provide health services targeted to the needs of persons with disabilities and services designed to minimize and prevent further disabilities (2-b), to provide health services close, insofar as is possible, to people's own communities, including in rural areas (2-c), to ensure that health professionals provide equal quality care on the basis of free and informed consent by pursuing certain actions (2-d), to prohibit discrimination in the provision of health and life insurance (2-e) and in the provision of health care or health services or food and fluids on the basis of disability (2-f).[71]

The CRPD recognizes the right 'to the enjoyment of the highest attainable standard of health' in Article 25 in line with the language and broad character of Article 12 ICESCR, placing, however, an explicit emphasis on the principles of equality and non-discrimination on the basis of disability. In literature it is argued that altogether the state obligations under Article 25 CRPD constitute the longest and most programmatic formulation of the right to health in international human rights law.[72] Indeed, the general formulation of Article 25 CRPD, namely the broad

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[68] As at 30 June 2016, only 48 States were parties to this Convention.

[69] P.A. Taran, 'Human Rights of Migrants: Challenges of the New Decade' *International Migration* 2000, Volume 38, Issue 6, pp. 7-51, p. 18.

[70] CRPD, adopted in New York, 13 December 2006, entered into force 3 May 2008, 2515 UNTS 3, UN Doc. A/RES/61/106. As at 30 June 2016, 166 States were parties to the CRPD, among which Greece (see Annex 2).

[71] Ibid.

[72] See, e.g., A. Hendriks & O. Lewis, 'Disability' in: Y. Jolly & B.M. Knoppers (eds) *Routledge*

wording and character of the right to health and its programmatic duties, largely alludes to the aforementioned argument. At the same time, in reaction, one might argue that Article 25 CRPD does not merely impose programmatic obligations but rather it tends to provide supplementary protection to a specific population group beyond those offered under Article 12 ICESCR. Specifically, this provision further informs the nature of the right to health in relation to its enjoyment by persons with disabilities as well as imposes more duties on States targeted to the health needs of this particular group that were not included at the time of the drafting of Article 12 ICESCR.

2.2.3. OTHER KEY SOURCES

In addition to human rights law, there are several other international documents (i.e., declarations, recommendations, plans, and regulations) that provide an interpretation of and/or are related to the right to health and as such these documents can also frame the standards and principles that national health legislation and policies should reflect.[73]

Since the WHO Constitution and ICESCR, the right to health has been addressed in several WHO Declarations, primarily in the Declaration of Alma-Ata and the World Health Declaration. The International Conference on Primary Health Care that was sponsored by the WHO and UNICEF resulted in the adoption of the 1978 Declaration of Alma-Ata on Primary Health Care, which proclaimed the right to health in its § I and drew attention to primary health care as a way to realize this right (see also section 3.4).[74] The Declaration underlined that primary health care at least encompasses education on prevailing health problems and the methods on preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against major infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.[75] It also affirmed the responsibility of States to provide for the health of their populations 'which can be fulfilled only by the provision of adequate

Handbook of Medical Law and Ethics, London and New York: Routledge 2014, pp. 78-97, p. 89.

73 See generally, e.g., J. Asher, *The right to health: a resource manual for NGOs,* London: Commonwealth Medical Trust 2004.

74 §§ I and VI of Declaration of Alma-Ata; Note that the UN General Assembly endorsed the 1978 Declaration of Alma-Ata on Primary Health Care by Res 34/43 of 19 November 1979.

75 § VII (3) of the Declaration, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

health and social measures' and by 'making fullest use' of (internal and external) resources to this end.[76] Yet, despite the Declaration's notable approach to (primary) health and its underlying determinants as well as to the progressive development of comprehensive health care for all, especially for those most in need,[77] in literature it is commented that WHO's past insufficient commitment to human rights impeded its effective implementation and finally led to its abandonment by WHO.[78]

The commitment to the principle embedded in WHO Constitution 'that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being' was reaffirmed by the World Health Assembly in 1998 in the 'World Health Declaration'.[79] It generally acknowledged the need to give effect to the 'Health-for-All policy for the twenty first century' through the implementation of relevant regional and national policies, without however identifying concrete measures to this aim. At the same time, the WHA is notable in its emphasis on the significance of reducing social and economic inequities in improving the health of the whole population and in particular to consider 'those most in need, burdened by ill-health, receiving inadequate health care or affected by poverty'.[80]

Meanwhile, beyond WHO declarations, since the early 1990s a series of other international conferences held under the auspices of the UN elaborated to a degree upon the meaning of health as a right, involving the extent of State's accountability, the position of vulnerable groups (e.g., women, children) as well as its connection to other rights.[81] The most notable in articulating health as a right were: the 1993 World Conference in Vienna, the 1994 International Conference on Population and Development (ICPD), the 1995 Fourth World Conference on Women (FWCW), the 1995 World Summit for Social Development (WSSD) and the 2000 Millennium Development Summit.

In June 1993 a World Conference on Human Rights was held in Vienna resulting in the adoption of the Vienna Declaration.[82] Most importantly, the Declaration

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[76] Ibid., §§ V, VII(5), VIII and X.

[77] Ibid., §§ I, V, VII (3) and (6).

[78] Ibidem supra note 15, B.M. Meier 2010, p. 178.

[79] WHO, Fifty-first World Health Assembly, WHA Doc. 51.7, 16 May 1998, Annex § I.

[80] Ibid., Annex § II.

[81] See, e.g., S. Gruskin & D. Tarantola, 'Health and Human Rights' in: S. Gruskin, M.A. Grodin, G.J. Annas & S.P. Marks (eds), *Perspectives on health and human rights*, New York and London: Routledge 2005, pp. 3-57, pp. 9-10; Ibidem supra note 11, B.C.A. Toebes 1999, pp. 74-76.

[82] World Conference on Human Rights, 14-25 June 1993, Vienna Declaration and Programme of Action, UN Doc. A/CONF.157/23, 12 July 1993.

emphasized the indivisibility and interrelatedness of all human rights, requiring all human rights (i.e., CP and ESC rights) to be treated 'in a fair and equal manner on the same footing, and with the same emphasis'.[83] Notably, the formulation of health as a right figures in several paragraphs of the Declaration. For example, at § 41 (section I) and §§ 47-48 (section II) the right to health of women and children is mentioned, respectively. Another health-related reference is found in §§ 11, 18 (medical care of women), 24 (health of vulnerable groups, such as migrant workers) of the Declaration, where health is articulated as a State's duty.[84]

Moreover, from 5 to 13 September 1994 an intergovernmental conference on population and development was held in Cairo, namely the ICPD.[85] After prolonged discussions and debates between participants, the Cairo Conference resulted in the consensus, *inter alia*, on two health goals to be achieved over the next 2 decades: the reduction of infant, child and maternal mortality[86]; and the provision of universal access to a full range of reproductive health-care services, including family planning.[87] At the same time, reproductive health was placed within the human rights framework, in that it was explicitly acknowledged that 'reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health'.[88]

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83 Ibid., § 5, section I.

84 Ibid., section I.

85 Programme of Action of the International Conference on Population and Development, adopted in 1994 by 179 States (note that in 1999 the UN General Assembly adopted the Key Actions for its further implementation), UN Doc. A/CONF.171/13/Rev.1.

86 Ibid., sections 1.12 and 1.14; See also, *inter alia*, sections 8.12, 8.15, 8.16 (child survival and health) and 8.20, 8.21, 8.22 (women's health and safe motherhood) of Programme of Action; See, e.g., J. Gottschalk, 'Cairo to Beijing: Disaster Averted', *Social Justice* 1995, Volume 22, Number 4, pp. 89-96, p. 89.

87 Ibid., sections 1.12 and 1.14; See also, *inter alia*, sections 7.5, 7.6 (reproductive health) and 7.12 (family planning) of Programme of Action.

88 Ibidem supra note 85 section 7.3; See, e.g., L.P. Freedman, 'Human Rights and the Politics of Risk and Blame. Lessons from the International Reproductive Health Movement' in: S. Gruskin, M.A. Grodin, G.J. Annas, S.P. Marks (eds), *Perspectives on health and human rights*, New York and London: Routledge 2005, pp. 527-536, p. 532. Freedman stressed that the ICPD 'marked the formal acceptance at the international level of a new paradigm in which health is intimately tied to rights'.

Further, the FWCW held in Beijing on 4-15 September 1995 resulted in the adoption of the Beijing Declaration which set out five strategic objectives aimed at enhancing women's health status worldwide.[89] The Beijing Declaration attempted to specify some concrete measures -albeit noncommittal as to the resources required for their implementation- that States should take to promote women's reproductive and sexual health.[90] Such measures include, *inter alia*, the provision of more accessible, available and affordable primary health care of high quality.[91] Moreover, the Beijing Declaration discerned that 'women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology… A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups*'*.[92]

Additionally, in March 1995, the WSSD took place in Copenhagen, where States -after hard-fought discussions- reached a consensus on the need to put people at the centre of development as well as on a number of health-related issues, with particular reference, *inter alia*, to the need to ensure full access to health care for women and children.[93] Note by way of background that following the conferences from the nineties, a number of (follow-up) conferences have been organized by the UN to monitor whether the stated goals in their previous plans of action had been accomplished (or not) and to reaffirm their respective commitments.[94] Meanwhile, in September 2000 at the Millennium Development Summit the

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89 Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, UN Doc. No. A/CONF. 177/20, Strategic Objectives C.1-C.5, §§ 106 -111.

90 Ibid., *inter alia*, §§ 30, 44 and section C, §§ 89-104; Ibidem supra note 86, J. Gottschalk 1995, p. 96; Note that the final text of the Beijing Declaration and Platform for Action was adopted by consensus after heated debates as to issues involving women's equality, health, abortion etc. (see, e.g., B. Roberts, 'The Beijing Fourth World Conference on Women', *The Canadian Journal of Sociology* 1996, Volume 21, No. 2, pp. 237-244, p. 240; M. Haslegrave & J. Havard, 'Women's Right to Health and the Beijing Platform for Action: The Retreat from Cairo?', *Health and Human Rights* 1995, Volume 1, No. 4, pp. 461-471.)

91 Ibid., § 106e.

92 Ibid., § 89.

93 World Summit for Social Development 1995, section 35, § c; Ibidem supra note 11, B.C.A Toebes 1999, p. 75; Ibidem supra note 86, J. Gottschalk 1995, p. 93.

94 See, e.g., the commitment to the Beijing Platform for Action was reaffirmed by: Beijing+5 (2000 - UN Doc. A/RES/S-23-3), Beijing+10(2005– UN Doc. E/CN.6/2005/L.1), Beijijg+15(2010- UN Doc. E/CN.6/2010/L.1) and Beijing+20(2015 - UN Doc. E/CN.6/2015/L.5); Ibidem supra note 73, J. Asher 2004, pp. 90 & 172-173.

international community made another global health-related commitment, reflected in the Millennium Declaration.[95] The Millennium Declaration identified 8 Millennium Development Goals (MDGs) to be achieved by the year 2015, four of which were clearly related to health: the reduction of infant mortality (Goal 4); the improvement of maternal health (Goal 5); the combat of HIV/AIDS, malaria and other diseases (Goal 6); and ensuring environmental sustainability (i.e., the reduction by half the proportion of people without sustainable access to safe drinking water - Goal 7).[96] In a general sense, four other of the MDGs, namely Goal 1 (to eradicate extreme poverty and hunger), Goal 2 (to achieve primary education), Goal 3 (to promote gender equality and empower women) and Goal 8 (to develop a global partnership for development) were closely connected to health in that their achievement can influence people's health.[97]

In 2013 the UN General Assembly reaffirmed its commitment to the Millennium Declaration and decided to determine and formulate the post-2015 development agenda, which will build on the foundations laid by the MDGs, fulfill the previous commitments and respond to new challenges.[98] Indeed, in October 2015 the adoption of the 2030 Agenda for Sustainable Development (the 2030 Agenda) by the international community marked the transition from the MDGs to the Sustainable Development Goals (SDGs).[99] The 2030 Agenda encompasses 17 goals, one of which is clearly related to health: to ensure healthy lives and promote well-being for all at all ages (Goal 3) and is linked with nine targets, which involve, *inter alia*, the reduction of maternal and child mortality, the achievement of universal health coverage as well as the reduction and management of global and national health risks.[100] At the same time, a considerable number of other goals includes health-related commitments, such as Goal 1 (to eradicate poverty), Goal 2 (to achieve food security and improved nutrition), Goal 4 (to ensure inclusive

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95 UN Millennium Declaration Resolution, UN GA Res. 55/2 §§ 11-23, UN Doc. A/55/L.2, 8 September 2000; E.D. Kinney, 'Realizing the international human right to health: the challenge of for-profit health care', *West Virginia Law Review* 2010, Volume 113, pp. 49-66, p. 55.

96 Ibid.

97 Ibid.

98 Outcome document of the special event to follow up efforts made towards achieving the Millennium Development Goals issued by the UN General Assembly, UN Doc. A/68/L.4, 1 October 2013, §§ 16-17.

99 *Transforming our world: the 2030 Agenda for Sustainable Development*, GA Res 70/1, UN Doc. A/RES/70/1, 21 October 2015.

100 Ibid., pp. 14 and 16-17.

and equitable quality education), Goal 6 (to ensure availability and sustainable management of water and sanitation) and Goal 13 (to combat climate change and its impacts).[101] Meanwhile, in a general sense the 2030 Agenda involves a commitment 'to be implemented in a manner that it is consistent with the rights and obligations of States under international law'.[102] Put simply, as regards to the right to health this statement indicates a commitment of the SDGs to the effective realization of this right in the context of the policies and programmes on these Goals, even though the 2030 Agenda does not explicitly address health as a right.

Last but not least, WHO, the core international and intergovernmental health organization can play an instrumental role in the field of health and human rights, primarily in the protection of the right to health of every individual by its engagement with the promotion and protection of public health.[103] In 2005 WHO adopted the International Health Regulations (IHR) in order to respond to 'exponential increase in international travel and trade, and emergence and reemergence of international disease threats and other health risks'.[104] The purpose and scope of these binding regulations are 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade'.[105] Importantly, Article

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101 Ibid., pp. 14-15, 17-19 and 23; Note that the impact of climate change on health is addressed in a binding manner in the Paris Agreement, particularly in its preamble, (see FCCC/CP/2015/ L.9/Rev.1, 12 December 2015 and FCCC/CP/2015/10/Add.1, 29 January 2016), adopted by the Conference of the Parties to the United Nations Framework Convention on Climate Change on its 21st session on 12 December 2015 (also called COP21). The Conference was held in Paris from 30 November to 13 December 2015. The Agreement is opened for signature (see Article 20§1 of the Agreement) and has not yet entered into force (see Article 21§1 of the Agreement). As at 30 June 2016, 19 States were parties to the Paris Agreement.

102 Ibid., § 18.

103 Ibidem infra note 110, GC No. 14, § 63; See also, J. Rothmar Hermann & B. Toebes, 'The European Union and Health and Human Rights' in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe,* Cambridge/Antwerp/ Portland: Intersentia 2012, pp. 51-79, p. 60.

104 WHO, International Health Regulations 2005- 2nd ed., Geneva: World Health Organization 2008. Available at <http://www.who.int/ihr/9789241596664/en/>. Note that the 2005 IHR, which entered into force on 15 June 2007, are a new version of 1969 Regulations and 196 States are parties to the regulations, among which Greece – automatically as a WHO Member State (status as of April 2013). In fact, Greece as a WHO Member State ratified the 2005 IHR by Law 3991/2011, *Official Government Gazette* – ΦΕΚ issue Α΄ 162/25-07-2011.

105 Ibid., Article 2 IHR.

3 § 1 of the Regulations provides that their implementation 'shall be with full respect for the dignity, human rights and fundamental freedoms of persons'.[106] As such, the IHR explicitly refer to human rights as well as acknowledge the significance of human rights protection in case of health emergencies of international concern, such as in the event of international outbreaks of infectious diseases.

In light of the preceding analysis, the series of the international conferences and documents helped in giving recognizable content to health as a right. These developments reflect the general -albeit strictly speaking not ideal- consensus of the international community on the close linkages between health and human rights in human rights treaties and on the need for concrete steps to be taken at international, regional and national levels for effectively realizing the right to health.[107]

2.2.4. GENERAL COMMENTS ON THE RIGHT TO HEALTH

In general, a General Comment (henceforth: GC) further elaborates on the content of rights and freedoms embedded in a treaty. A GC is a non-binding document, adopted by a UN treaty monitoring body that seeks to help States in the interpretation of a respective treaty and the implementation of their treaty obligations, as a result. It is an authoritative source which may guide States regarding the scope and nature of their obligations under a respective treaty.[108] In particular, the CESCR and the CRC Committee, the human rights treaty monitoring bodies which oversee the implementation of ICESCR and CRC respectively, have both developed the practice of adopting GCs to clarify the normative framework of the various rights enshrined in ICESCR and CRC, among which the meaning and implications of the right to health.[109]

Notably, the CESCR adopted in 2000 GC No. 14 to interpret Article 12 on the right to the highest attainable standard of health (right to health).[110] Likewise, the

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106 Ibidem supra note 104.

107 See for a general approach concerning all human rights supra note 81, S. Gruskin & D. Tarantola 2005, p. 10.

108 A. Aust, *Handbook of International Law* (2nd ed.), Cambridge: Cambridge University Press 2010, p. 11; Ibidem supra note 21, H.P. Hestermeyer, p. 121.

109 Website of the Office of the UN High Commissioner for Human Rights, Monitoring Economic, Social and Cultural Rights www.ohchr.org/EN/HRBodies; Note that the CESCR is a structural institution formed not by the international treaty, the ICESCR, but by the Economic and Social Council of the United Nations (ECOSOC), whereas the CRC Committee was formed by an international treaty, the CRC.

110 UN CESCR, General *Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000.; Of note, as regards to the right to sexual

CRC Committee issued in 2013 GC No. 15 to interpret Article 24 on the right to health of the child.[111] Both GCs attempt to elucidate the normative content of the right to health, as included in Articles 12 ICESCR and 24 CRC, address the issues of implementation and enforcement by delineating the substantive content of the resulting state obligations and the responsibilities of non-State actors.[112] In particular, both GCs tend to provide guidelines concerning the nature of State's obligations with respect to the right to health and identify possible violations of it.[113] In interpreting the right to health, both GCs extensively stipulate that the right to health is not a right to be healthy; it contains both freedoms and entitlements.[114] The CESCR provides that the right to health is an inclusive right, encompassing not only individual and population healthcare (both preventive and curative), but also attempting to enhance the determinants of health, such as access to safe and potable water, healthy occupational and environmental conditions, and access to health-related education and information, including information on sexual and reproductive health.[115] As such, the right to health both encompasses the legal entitlement to health care and to conditions necessary for the realization of the highest attainable standard of health. Similarly, the CRC Committee in GC No. 15 stresses that children not only have a right to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative health care, but also have 'a right to opportunities to survive, grow and develop to their full potential and live in conditions that enable them to attain the highest attainable standard of health through the implementation of programmes that address the underlying determinants of health'.[116]

Of note, both the CESCR and the CRC Committee broadly underscore -at a relatively high level of abstraction- the importance of international co-operation as part of achieving the right to health as set out in Articles 2 § 1 ICESCR as well as 4 and 24 § 4 CRC respectively, without specifying this obligation in great detail

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and reproductive health, an integral component of the right to health (§1), the CESCR adopted General Comment No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016.

111 UN CRC Committee, *General Comment No. 15: The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, UN Doc. CRC/C/GC/15, 17 April 2013, §§ 1-4.

112 Ibidem supra note 110, GC No. 14, §§ 2, 30-52; Ibid., GC No. 15, §§ 2-4, 71-74 and 75-85.

113 Ibid., GC No. 14 §§ 30-52 and GC No. 15 §§ 51 and 71-74.

114 Ibidem supra note 110, GC No. 14, § 8; Ibidem supra note 111, GC No. 15, § 24.

115 Ibidem supra note 110, GC No. 14, § 11.

116 Ibidem supra note 111, GC No. 15, § 4.

by way of concrete measures required by States (see section 4.4).[117] Generally speaking, it is indicated that countries with high income have the responsibility to help low-income (developing) countries in the realization of the right to health. On the other hand, low-income countries have a responsibility to seek appropriate international co-operation in order to strengthen their policies for the protection of their population's health and fulfil their core obligations arising from the right to health.[118]

All in all, although GCs No. 14 and No. 15 do not have binding legal authority, an elaboration of the right to health is attempted through the interpretation of the CESCR and the CRC Committee in these Comments, respectively. Note that the Special Rapporteur on the right to the highest attainable standard of health ('right to health') through his work has also attempted to reinforce the principles established in the respective GCs at the operational level (see section 4.2.3). In 2002, the then Commission on Human Rights appointed the first Special Rapporteur on the Right to Health with the obligation, *inter alia*, to conduct missions in various countries and submit reports on the realization of the right to health (founding UN Res 2002/31).[119] The role of the Special Rapporteur as well as the distinctive features of the right to health as laid down in GCs No. 14 (CESCR) and 15 (CRC Committee) with respect to the nature of state measures required for the realization of the right to health are more fully addressed in subsequent Chapters. Last but not least, we should keep in mind, as rightly pointed out in literature, that GCs should not extend the scope of a treaty obligation from what is 'conventionally agreed' to 'what might be considered to be desirable' given that these documents do not have legal weight.[120] As such, Riedel pointedly observes that the CESCR,

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117 Ibidem supra note 110, GC No. 14, §§ 38-41 and 45; Ibidem supra note 111, GC No. 15, §§ 86-89.

118 Ibidem supra note 110, GC No. 14, §§ 38-40 and 45; See, also, Section 4.4; Ibidem supra note 73, J. Asher 2004, p. 51.

119 Note by way of background that the Special Rapporteur on the Right to Health is required under the mandate to prepare reports that offer insights into the normative framework of the right to health and, ultimately, into its effective realization. These reports involve annual reports to the then Commission on Human Rights, the Human Rights Council and the UN GA, as will be discussed more elaborately in section 4.2.3; See website of the UN <www.ohchr.org/EN/HRBodies/SP/ Pages/Introduction.aspx>. See, UN Commission on Human Rights, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health -Resolution 2002/31*, 22 April 2002, UN Doc. E/CN.4/RES/2002/31, § 5.

120 See, e.g., E. Riedel, 'The Human Right to Health: Conceptual Foundations' in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 27.

like all treaty bodies, has to 'draw a fine line between interpreting … and legislating, which is up to the contracting states'.[121]

2.3. HEALTH AS A RIGHT AT THE REGIONAL LEVEL: A FOCUS ON EUROPE

Generally speaking, three regional human rights systems have been mainly created for protecting human rights, including one in Europe, the Americas and Africa.[122] Europe has the oldest human rights system within which considerable developments have taken place during the years.[123] Thereto, in terms of the examination of regional documentary sources of the right to health, the treaties that recognize the right to health and will be reviewed are key legally binding documents applicable in the European region.[124]

European Human Rights System:

In Europe, both the Council of Europe (CoE) and the European Union (EU) aim to promote human rights in general and recognize the right to health in particular in diverse legal documents (see below). Most notably, within the context of the CoE, it was not until 1961 when the European Social Charter (ESC) enshrined a

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121 Ibid., p. 27.

122 Ibidem supra note 22, H.J. Steiner et al. 2008, p. 925.

123 Ibidem supra note 22, H.J. Steiner et al. 2008, pp. 925-926; Another reason to opt for the examination of the European human rights system in relation to the recognition of the right to health is that Part II of the study will focus on a European country, Greece.

124 See other regional right to health provisions, e.g., Under the American Human Rights System: the American Declaration of the Rights and Duties of Man (ADHR, 1948) includes a general provision in Article 11; the American Convention on Human Rights (referred as Pact of San Jose, 1969) recognizes ESC rights in a single article, namely Article 26, without referring specifically to the right to health; the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador, 1988) includes a right to health provision in Article 10 and recognizes several other health-related rights, including, *inter alia*, Articles 9 (social security) and 11 (living in a healthy environment); Under the African Human Rights System: The African Charter on Human and People's Rights ('*Banjul Charter',* 1981) recognizes the right to health in Article 16; The African Charter on the Rights and Welfare of the Child (1990) includes a right to health provision in Article 14 as well as other health-related provisions: Articles 11§ 2 (h) on the promotion of children's understanding of basic health care in schooling, 20 § 1 (b) on the parental responsibility for ensuring living conditions necessary for the development of the child and 20 § 2 (a) on appropriate measures to be taken by States to provide material assistance and support programs with respect to children's health.

right to protection of health (Article 11) and in 1997 when the Biomedicine Convention proclaimed a right to equitable access to health care (Article 3). Thereby, this section will analyze the relevant key provisions on the right to health in the European region, namely relevant legal documents in the CoE, involving relevant case law of the European Court of Human Rights (ECtHR) and the European Committee of Social Rights (ECSR), and within the EU.

1 Article 11 (Revised) European Social Charter

During the drafting period of the ICESCR, the ESC[125] was also being drafted and adopted in 1961 to ensure economic and social human rights, among which a 'right to protection of health' under Article 11. Notably, a revised version of the ESC was adopted in 1996, as a way of 'revitalizing' the Charter that was perceived by its drafters as a need primarily as regards the strengthening of economic and social rights in the European region due to the emergence of liberalized market economies in the early 1990s in several Central and Eastern European countries.[126] Meanwhile, this revitalization process did not introduce substantial changes to the initial text of Article 11 ESC.[127] In particular, the (Revised) ESC includes in Article 11 a 'right to protection of health', by stipulating that contracting States, with a view to ensuring the effective exercise of this right, are required to undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed, *inter alia:* '1. to remove as far as possible the causes of ill-health'; '2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health'; and '3. to prevent as far as possible epidemic, endemic and other diseases as well as accidents'.[128]

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125 European Social Charter, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) European Social Charter, 3 May 1996, entered into force 1 July 1999, ETS 163.; The only new element included in Article 11 Revised ESC is the phrase 'as well as accidents'; Note also that as at 30 June 2016 the majority of the Member States of the CoE (i.e., 34 Member States out of total 47 Member States) have signed and ratified the (Revised) ESC, among which Greece (see Annex 2).

126 See, e.g., G. de Beco, *Human Rights Monitoring Mechanisms of the Council of Europe*, London/ New York: Routledge 2012, p. 72 (citing relevant studies).

127 Ibidem supra note 125; It is noteworthy that the content of the ESC was enriched and new Articles were included in the revised version of the Charter, such as Article 17, Article 30 and Article E that are relevant to the protection of health; Ibid., G. de Beco 2012, pp. 73-74.

128 ESC 1961 (Revised), adopted on 3 May 1996, entered into force on 1 July 1999, 2151 UNTS 277, ETS 163; See Annex 2.

Unlike the ICESCR and the CRC, the Charter does not include clauses on the progressive realization and on the availability of resources in relation to the realization of the rights enshrined in the Charter, such as the right to health.[129] Additionally, the (Revised) ESC in Article 11 employs different terminology to define health as a right; embraces individual responsibility in matters of health; pays attention to co-operation with public and private organizations as part of States' responsibility; and focuses on diverse health-related measures, even though it interprets the right to health in expansive terms just as in international human rights law (i.e., see Article 12 ICESCR, Article 24 CRC, etc.). At the same time, Article 11 (Revised) ESC highlights that the right to health is more than a right to medical care and it covers the causes of ill-health.[130] Indeed, as comprehensively explained by the Secretariat of ESC Article 11 (Revised) ESC provides for a broad framework of measures encompassing both health promotion and healthcare provision in case of sickness.[131] In particular, health promotion involves preventive measures (i.e., healthy environment, immunization and epidemiological monitoring, prevention of accidents), health educational measures (i.e., personal behaviour, public awareness, counselling and screening) and the issuing and implementation of health regulations (i.e., occupational health and safety, children's health, maternal health and elderly person's health).[132] Healthcare provision includes measures associated with the functioning of healthcare facilities and the overall system of health care as to be responsive to avoidable health risks and accessible to the entire population.[133]

In the meantime, the (Revised) ESC contains several other extensive provisions which guarantee health-related rights and are relevant to the promotion and protection of health.[134] Particularly, Article 3 lays down obligations to ensure health and safety at work. Moreover, the Charter under Article 13 recognizes a right to social and medical assistance by stipulating that all nationals and people on the territory without adequate resources have the right to social and medical assistance in case of sickness. Further, the health and well-being of children and young persons are protected by Articles 7 (the right of children and young persons to protection) and 17 (the right of children and young persons to social, legal and economic

129 Ibidem supra note 126, G. de Beco 2012, p. 74.

130 Ibidem supra note 128.

131 The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC, March 2009.

132 Ibid., pp. 2-9.

133 Ibid., pp. 9-10.

134 For health-related rights in the (Revised) ESC, see also Annex 1.

protection), while the health of pregnant women is addressed in Articles 8 (special protection for employed pregnant women) and 17 (the right of children and young persons to social, legal and economic protection). Additionally, the health of elderly persons is covered by Article 23, whilst the protection and assistance to migrants and their families are provided by Article 19. Finally, Articles 12 (the right to social security) and 14 (the right to benefit from social welfare services) are also health-related rights.[135]

In light of the aforementioned provisions, it can be observed that the Charter pays particular attention to the position of vulnerable groups, namely children and young persons, women, migrant workers and their families, and elderly persons.[136] Added to these provisions, it is notable that the Charter embraces a non-discrimination clause in Article E (prohibition of all forms of discrimination in the application of the rights guaranteed by the treaty).[137] However, the scope of the Charter with regard to persons afforded protection is limited by its Appendix, including foreigners only in so far as they are nationals of other Contracting States lawfully resident or working regularly within the territory of the Party concerned.[138] The European Committee of Social Rights (ECSR) -the treaty monitoring body of the (Revised) ESC which allows the lodging of collective complaints in addition to the system of periodic reporting[139]-, albeit aware of this provision, expanded the Charter's scope of application as to include non-nationals (e.g., undocumented migrants in certain circumstances) in its (non-binding) decisions (see section 4.3).[140]

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135 Ibidem supra note 128; Annex 1.

136 Ibid.

137 Ibid.

138 (Revised) ESC – Appendix, § 1. It reads as follows: 'Without prejudice to Article 12, paragraph 4, and Article 13, paragraph 4, the persons covered by Articles 1 to 17 and 20 to 31 include foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned, subject to the understanding that these articles are to be interpreted in the light of the provisions of Articles 18 and 19.'

139 The AP to ESC provided a system of collective complaints, adopted 9 November 1995 (entered into force in July 1998), CETS 158; See, Articles 1-2 AP ESC.

140 See, e.g., *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint no. 14/2003, 3 November 2004, §§ 31-34 and §§ 36-37 - Notably, the ECSR found a violation of Article 17 (Revised) ESC which provides an expansive protection (social, legal and economic protection) with respect to children; *Defence for Children International (DCI) v. Belgium* (Complaint No. 69/2011, 20 November 2012) § 152- The ECSR found a violation of Articles 11(1) and (3), and 17 (Revised) ESC, and *Defence for Children International (DCI) v. The Netherlands* (Complaint No. 47/2008, 27 October 2009) §§ 25, 66 & 77 – The ECSR found a violation of Article 17(1)c (Revised) ESC which is applicable also to children unlawfully present in the Netherlands.

Last but not least, an interpretation of the right to health can be found in the case law of the ECSR, whose work can contribute to the advancement of the legal nature of the right to health, a contentious issue ever since the emergence of ESC rights (see section 4.3).[141]

2 Article 3 Biomedicine Convention

Another significant document drafted within the context of the CoE is the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Biomedicine Convention). While the right to health in the (Revised) ESC is recognized in expansive terms involving not only healthcare but also the underlying determinants of health, the Biomedicine Convention takes a narrower approach to this right by mainly focusing on access to healthcare. In particular, Article 3 stipulates that 'parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality'.[142]

Nonetheless, the formulation of Article 3 Biomedicine Convention does not provide clarity on its scope and the nature of measures required by States. To this aim, the Committee of Bioethics has provided an interpretation of Article 3 in the Explanatory Report to the Convention on Human Rights and Biomedicine.[143] Accordingly, the term 'health care' is interpreted as to encompass services offering diagnostic, preventive, therapeutic and rehabilitative interventions designed to maintain or enhance a person's state of health or alleviate a person's suffering.[144]

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141 See, e.g., J. Sellin, 'Justiciability of the Right to Health - Access to Medicines. The South African and Indian Experience', *Erasmus Law Review* 2009 Volume 2 Issue 4, pp.445-464, p. 451.

142 The Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine CETS No. 164 entered into force on 1 December 1999. As at 30 June 2016, 29 Member States of the CoE have ratified the Biomedicine Convention, among which Greece (see Annex 2). Note that several other provisions in the Biomedicine Convention are health-care related, such as Articles 5-9 (consent to treatment), 10 (private life and the right to information), 11-14 (genetics and the prohibition of discrimination), 15-18 (scientific research) and 19-22 (organ and tissue removal from living donors for transplantation purposes); For an overview of health-related rights in the Biomedicine Convention, see also Annex 1.

143 Explanatory Report to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the application of biology and medicine, ETS No. 164.

144 Ibid., § 24.

In addition, the Explanatory Report observes that Article 3 imposes a general state obligation to ensure equitable access to health care of appropriate quality in accordance with a person's medical needs by requiring of States to use their best endeavors to realize this objective.[145] Also, the term 'equitable access to health care' implies 'first and foremost the absence of unjustified discrimination'[146] and ensuring a satisfactory degree of care[147]. Aasen pointedly argues that this wording must be understood as to encompass a consideration for the particular and diverse needs of all population groups in the society by way of adopting targeted interventions on the part of States.[148]

All in all, we can conclude that the wording of Article 3 implies only in principle a narrower scope than Articles 11 (Revised) ESC (CoE level) and 12 ICESCR (UN level), as its implementation requires States to design an elaborated framework of measures, not just in the area of healthcare. In essence, given that some determinants of health have an effect on access to healthcare (i.e., socio-economic determinants) and are beyond the control of healthcare, the implementation of the general state obligation under Article 3 involves also the consideration of such health determinants on the part of the States within the context of designing targeted health policies to achieve this end.[149]

3 European Convention for the Protection of Human Rights and Fundamental Freedoms

Within the context of the CoE, the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, 1950) is another regional legal source which is essentially concerned with the protection of CP rights (life, privacy etc.) and not with ESC rights, like the right to health.[150] Even though the right to

145 Ibid., §§ 23-24.

146 Ibid., § 25.

147 Ibid., § 25.

148 H.S. Aasen 'The Right to Health Protection for the Elderly: Key Elements and State Obligations', in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds), *Health and Human Rights in Europe,* Cambridge/Antwerp/Portland: Intersentia 2012, pp. 273-299, p. 285.

149 Ibid., see for a similar approach as to the scope of Article 3 Biomedicine Convention.

150 European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights) adopted 4 November 1950, entered into force 3 September 1953, 213 UNTS 221, CETS No. 005. Note that all 47 Member States of the CoE, among which Greece, have ratified the ECHR and that the accession of the EU to the ECHR has become a legal obligation under the Treaty of Lisbon (legal basis: Article 59 § 2 ECHR as amended by Protocol No. 14 to the ECHR which entered into force on 1 June

health is not enshrined in the ECHR, the ECtHR has illustrated through its legally binding judgments that the ECHR encompasses several other rights that are health-related and whose enjoyment has implications in the field of health (care)[151], involving *inter alia* the right to life (Article 2)[152], the prohibition of torture (Article 3)[153] and the right to private and family life (Article 8)[154], and the prohibition of discrimination (Article 14).[155]

By way of example we can discern that Article 3 ECHR, which prohibits torture and inhuman or degrading treatment, can be perhaps an effective tool for the indirect protection of health.[156] In fact, the ECtHR, as will be elaborately discussed in section 7.4.1, has found that solely in 'exceptional circumstances' (i.e., 'critical stage in an individual's fatal illness') the expulsion of a person with

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2010); See also, I. Brownlie & G.S. Goodwin-Gill, *Brownlie's Documents on Human Rights* (6th ed.), Oxford: Oxford University Press 2010, p. 681.

151 Under Article 34 ECHR any individual, non-governmental organization or group of individuals are entitled to lodge complaints with the ECtHR concerning claims on a violation of the rights set forth in the ECHR by one of the State parties of ECHR. See, e.g., A. Hendriks, 'The Council of Europe and Health and Human Rights', in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 23-50, p. 27; For health-related rights in the ECHR, see Annex 1.

152 For case law of the ECtHR with relevance in the field of health that has been argued under Article 2 ECHR (i.e., involving issues, such as physical ill-treatment, protection of health of individuals, denial of health care, medical negligence) see, e.g., *Erikson v. Italy* (Application no. 37900/97) ECtHR 26 October 1999; *Cyprus v. Turkey* (Application no. 25781/94) ECtHR 10 May 2001, § 219; *Oyal v. Turkey* (Application no. 4864/05) ECtHR 23 March 2010, §§ 66-69.

153 For health-related case law of the ECtHR that has been argued under Article 3 ECHR (i.e., involving issues such as damage of an individual's physical/mental health) see, e.g., *Paladi v. Moldova* (Application no. 39806/05), ECtHR 10 March 2009; *Kaçiu and Kotorri v. Albania* (Application nos. 33192/07 and 33194/07) ECtHR 25 June 2013, §§ 89, 98 and 100; *Gäfgen v. Germany* (Application no.22978/05) ECtHR 1 June 2010, §§ 79 and 131-132.

154 For health-related case law of the ECtHR that has been argued under Article 8 ECHR (i.e., involving issues, such as the respect of an individual's physical and psychological integrity, personal autonomy – refusal of proposed medical treatment) see, e.g., *Glass v. the United Kingdom* (Application no. 61827/00) ECtHR 9 March 2004, §§ 70-83; *Tysiąc v. Poland* (Application no. 5410/03) ECtHR 20 March 2007, §§ 105-108.

155 For health-related case law of the ECtHR that has been argued under Article 14 ECHR (i.e., involving issues, such as a person's health status constitutes a protected ground against discrimination) see, e.g., *Kiyutin v. Russia* (Application no. 2700/10) ECtHR 10 March 2011, §§ 9 and 57; *I.B. v. Greece* (Application no. 552/10) ECtHR 3 October 2013, § 73.

156 Ibid.; Ibidem supra notes 150 and 151.

a life-threatening disease to a country lacking essential medical care would amount to inhuman treatment and constitute a violation of Article 3 ECHR.[157] Nonetheless, the Court by emphasizing the exceptional character of the particular case expressed its hesitance to engage such a positive state obligation under the Convention in similar cases (i.e., the deportation of a seriously ill individual to his or her country of origin) where the individual's illness does not reach a terminal stage (i.e., imminent death or serious physical and mental suffering).[158] As such, we can conclude that the decisions of the ECtHR on a (alleged) risk of ill-treatment in deportation cases will be each time determined by the particular circumstances of each individual case brought before it.

4 Article 35 of Charter of Fundamental Rights of the European Union

At EU level, Article 35 of Charter of Fundamental Rights of the European Union (CFREU, 2000) stipulates a right to health in the sense that '*Everyone has the right* of access to preventive health care and the right to benefit from medical treatment under the conditions established under national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities' [emphasis added].[159] From the aforementioned provision two basic legal implications arise. This provision forms the basis of the individual entitlements of EU citizens to both preventive health care and to medical treatment under the conditions set by individual European Countries.[160] Additionally, it establishes an obligation on the EU institutions in terms of Community policies and activities of the Union, to the extent that the EU has competence.[161] Nonetheless,

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157 *D. v. the United Kingdom* (Application no. 30240/96) ECtHR 2 May 1997, §§ 53- 54.

158 Note that in 'similar' cases to that of *D. v the United Kingdom,* namely when the availability of treatment in country of destination in conjunction with the healthcare needs of an individual has been invoked against a decision on expulsion, the ECtHR held otherwise, see, e.g., *N. v. the United Kingdom* (Application no. 26565/05), ECtHR 27 May 2008; *Salkic and Others v. Sweden* (Application no. 7702/04), ECtHR 29 June 2004, p. 10; *Ndangoya v. Sweden* (Application no. 17868/03) ECtHR 22 June 2004, p. 13; *Arcila Henao v. the Netherlands* (Application no. 13669/03), ECtHR 24 June 2003, p. 8; *Bensaid v. the United Kingdom* (Application no. 44599/98), ECtHR 6 February 2001, § 38.

159 Charter of Fundamental Rights of the European Union, *Official Journal of the European Communities,* Doc. 2000/C 364/01. Of note, the Charter has become legally binding on the EU with the entry into force of the Treaty of Lisbon on 1 December 2009, Article 6 § 1 TFEU (see infra note 165). <http://www.europarl.europa.eu/ charter/pdf/text_en.pdf>

160 Ibid.; For a similar approach see, e.g., Ibidem supra note 148, H.S. Aasen 2012, p. 234.

161 As to the scope of the Charter, see Article 51 CFREU. Note that Article 51§ 1 CFREU

given the broad formulation of this provision, its wording is not explicit on the issue whether non-nationals, such as undocumented migrants, are entitled to access preventive health care and to benefit from medical treatment.[162] This provision gives discretionary power to individual European Countries to decide on this issue through the elaboration of their own health policy. Indeed, some scholars argue that the broad wording of the provisions of the Charter may be problematic when it comes to be applied[163], while others argue that these provisions are likely to be qualified in practice -albeit phrased in absolute terms- when they are interpreted and applied.[164]

Meanwhile, the wording of Article 35 CFREU is similar to that of Article 168 Treaty on the Functioning of the European Union (TFEU), which replaced Article 152 EC Treaty (TEC) with the adoption of the Lisbon Treaty (2009).[165] Article 168 § 1 states that 'A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'.[166] This provision is further elaborated in Article 168 § 7 which stipulates that the Union 'shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them'.[167] The TFEU makes it explicit that Member States have the prime competence over the design and development of health care. At this stage, it is important to note that the Union can regulate this competence (see Article 168 § 4 (a)-(c) TFEU) through several actions-mechanisms. For instance, under Article 288 TFEU this could be achieved

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provides that the institutions and bodies of the EU as well as the Member States, to whom the Charter is addressed shall 'respect the rights, observe the principles and promote the application thereof *in accordance with their respective powers*' [emphasis added].

162 See, e.g., Ibidem supra note 148, H.S. Aasen 2012, p. 235, see for an analogous approach.

163 See, e.g., Ibidem supra note 103, J. Rothmar Herrmann & B. Toebes 2012, pp. 51-79, p. 57.

164 See, e.g., J. McHale, 'Fundamental rights and health care', in: El. Mossialos, G. Permanand, R. Baeten and T.K. Hervey, *Health Systems Governance in Europe: The Role of European Union Law and Policy*, Cambridge: Cambridge University Press 2010, pp. 282-314, p. 298.

165 Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community, signed at Lisbon 13 December 2007, *Official Journal of the European Union*, 17 December 2007, Doc. 2007/C 306/01. Available at <www.eur-lex.europa.eu>

166 Consolidated Version of the Treaty of on the Functioning of the European Union, *Official Journal of the European Union*, 26 October 2012, Doc. 2012/C 326/47. Available at <www.eur-lex.europa.eu>

167 Ibid.

by way of issuing Directives (i.e., EU secondary law within EU legal order) that have implications in the area of health and as such they can provide a common legal framework across all EU Member States when they are addressed to all these States (e.g., see Racial Equality Directive 2000/43/EC - Part II, section 8.3.2).[168]

Nevertheless, since the emergence of the economic crisis within the EU (2009-2010), several EU Member States, such as Greece (see Part II), have gradually introduced a number of austerity measures in the health sector in order to address the hardly manageable rising health care costs. Such initiatives may be translated into more and increasing user fees for health care, which in turn may adversely impact on disadvantaged groups within the population (i.e., such as chronically ill, Roma, undocumented migrants) and increase their vulnerability, as a result. As such, one cannot ignore the fact that such initiatives further contribute to the rising socio-economic health inequalities in the EU (see Part II, chapter 6). Indeed, Hendriks pointedly argues that the EU's competences in the area of healthcare remain rather limited notwithstanding the entering into force of the TFEU (2009) and the CFREU (2009).[169]

2.4. HEALTH AS A RIGHT AT THE NATIONAL LEVEL: CONSTITUTIONAL PROVISIONS

The right to health, however phrased at the international and regional level, is also found to be enshrined in national constitutional law. Illuminating perhaps is the report by the first UN Special Rapporteur on the Right to Health (Paul Hunt) where he stresses that the right to health or the right to healthcare is included in over 60 national constitutions and more than 40 national constitutions contain health-related rights, such as the right to reproductive health or the right to a healthy environment.[170] Hence, this section examines a compilation of explicit or implicit

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[168] For a definition of the term 'Directive' see website of the EU <http://europa.eu/eu-law/decision-making/legal acts/index_en.htm>. Note that Article 288 TFEU provides that each EU country will decide on the way of applying an EU Directive within its legal order for achieving the goals set under the Directive.

[169] A. Hendriks, 'High-quality of Care throughout Europe — But Do We Speak the Same Language?' (editorial), *European Journal of Health Law* 2016, 23, pp. 1-4, p.1.

[170] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc. E/CN.4/2003/58, 13 February 2003, § 20; Ibidem supra note 14, E.D. Kinney & B. Clark 2004, pp. 285-355; WHO Regional Office for South-East Asia, *The Right to Health in the Constitutions of the Member States of the World Health Organization South-East Asia Region*, India: WHO 2011.

references to health as a right in national constitutions with a primary focus on Europe.[171] Particularly, a number of constitutional provisions, which illustrate the various dimensions of the interpretation of the right to health as well as the different types of constitutional provisions, will be mentioned in an exemplary manner.[172] In some of the constitutional provisions mentioned, it becomes clear that health is a constitutionally protected right, whereas in others it may only be regarded as a state obligation (see below).

More specifically, several constitutional provisions have taken various forms with clauses referring either directly or indirectly to the right to health. The Constitution of Hungary, for example, in its first paragraph of Article XX sets forth 'the right to physical and mental health'.[173] Here, the right to health is worded in very similar language to that of Article 12 ICESCR. Furthermore, the second paragraph of Article XX of the Constitution contains a list of seven areas of a State's responsibility. Meanwhile, Article XXI of the Constitution recognizes a right to a healthy environment. In addition, the Constitution of Italy contains an individual right to health.[174] Moreover, Greece[175], Portugal[176], Romania[177], Slovakia[178], Estonia[179] and Spain[180] have constitutional provisions that include an explicit right to protection of health and establish state obligations for the promotion of the health. Furthermore, Bulgaria and Slovenia in their constitutions provide explicitly for a right to health care rather than a right to health, which is made subject to insurance and national legal conditions, as well as establish specific state obligations to guarantee the protection of their population's health.[181]

Further, it is noteworthy that other countries do not have an individual right

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171 Ibid.; The constitutions listed in this section are available at the following web sites: constitution finder, <http://www.confinder.richmond.edu> and <http://www.wipo.int/wipolex/en>; See generally, e.g., G. Robbers (ed.), *Encyclopedia of world constitutions,* 3-Volume set, NY: Infobase publishing 2007.

172 Status of Constitutional Provisions as at 30 June 2016.

173 Constitution of Hungary (The Fundamental Law of Hungary, 2011, repealed the Constitution of 1949, as amended to 2013), Article XX (1).

174 Constitution of Italy (1947, as amended to 2012), Article 32.

175 Constitution of Greece (1975, as amended to 2008), Articles 5 § 5 and 21§ 3.

176 Constitution of Portugal (1976, as amended to 2005), Article 64.

177 Constitution of Romania (1991, as amended to 2003), Article 34.

178 Constitution of Slovakia (1992, as amended to 2014), Article 40.

179 Constitution of Estonia (1992, as amended to 2011), Article 28.

180 Constitution of Spain (1978, as amended to 2011), Sections 43 and 50.

181 Constitution of Bulgaria (1991, as amended to 2007), Article 52 and Constitution of Slovenia (1991, as amended to 2013), Article 51.

to health enshrined in their constitutions, but nevertheless approach it from the angle of state obligations with respect to health, namely to provide health care or to improve public health. The word 'right' is not depicted in these constitutions. For instance, Luxembourg[182], Switzerland[183], Latvia[184], Liechtenstein[185] and Netherlands[186] have constitutional provisions that define the state's duty either to provide medical aid or to protect human health or to maintain public health or to promote the health of the population, respectively. Additionally, the constitution of Switzerland under Article 118 § 2 establishes specific state obligations for the protection of health.

In the meantime, other countries include the right to health in broader constitutional provisions on welfare, social security, life and human dignity, while others restrict the right to health to principles of State policy. For instance, the right to health is enshrined in the Constitution of Finland as part of a provision covering the right to social security.[187] Likewise, the right to health, stipulated in the Belgian Constitution, is directly related to the right to life and human dignity.[188] Notably, in the Indian Constitution health is covered in terms of the 'Directive Principles of State Policy' by establishing a clear role for the State in public health policy.[189]

All in all, this non-exhaustive analysis of a number of constitutional provisions reveals that the right to health has received different approaches in the various national constitutions. While some constitutions expressly include provisions for it (e.g., a right to protection of one's health), others have no single provision on the right to health and this right is rather inferred from other rights. At the same time, in some countries the right to health is restricted to principles of State policy (i.e., to the establishment of a role for the State in health policy). Nevertheless, we may conclude that however codified, the recognition of the right to health in national constitutional law tends to provide a path for enhanced protection and promotion of health at the national level (see Part II, chapter 5).

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182 Constitution of Luxembourg (1868, as amended to 2009), Article 23.
183 Constitution of Switzerland, (1999, as amended to 2014), Articles 12, 41 § 1(b) and 118.
184 Constitution of Latvia (1922 reinstated 1991, as amended to 2014), Article 111.
185 Constitution of the Principality of Liechtenstein (1921, as amended to 2010), Article 18.
186 Constitution of Netherlands (1815, as amended to 1983-2008), Article 22 § 1.
187 Constitution of Finland (1999, as amended to 2011), Section 19.
188 Constitution of Belgium (1831, as amended to 2014), Article 23.
189 Constitution of India (1949, as amended to 2015), Article 47.

2.5. THE RIGHT TO HEALTH AND OTHER HUMAN RIGHTS

While the internationally guaranteed right to health is a key right, it is noteworthy that several other human rights have the potential to protect health and are relevant in a healthcare domain, as already mentioned in previous sections.[190] In particular, several human rights retain a health dimension and are connected to health, including the right to life, the right to freedom from inhuman and degrading treatment, the right to privacy, the right to information and the right to a private and family life (see also Annex 1). It can, thus, be argued that the right to health is interdependent with such rights. Enjoyment of the right to health, as its definition makes clear, requires among other things respect for several other rights that are integral components of the right, as pointed out by the CESCR's interpretation on the right to health in its GC No. 14.[191] This reflects the indivisibility and interdependence of all human rights[192], as was affirmed in the Vienna Declaration and Programme of Action, adopted in 1993.[193] In this spirit, in scholarly writings it is maintained, for example, that 'the goal of linking health and human rights is to contribute to advancing human well-being beyond what could be achieved through an isolated health- or human rights-based approach'.[194]

Notably, the right to health as defined in GC No. 14 is closely related to and dependent upon the realization of a number of other human rights, as contained in the International Bill of Rights,[195] which are related not only to the social determinants of health (e.g., housing, education, food and work), but also to civil

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190 Ibidem supra note 110, GC No. 14, § 3; See, e.g.,, R.J. Cook & M.F. Fathalla 'Advancing Reproductive Rights Beyond Cairo and Beijing' *International Family Planning Perspectives* Sep., 1996, 22, no. 3, pp. 115-121, p. 116; B. Toebes, 'The Right to Health and Other Health-Related Rights' in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 83-110, p. 83.

191 Ibidem supra note 110, GC No. 14, § 1 and GC No. 22 , § 1.

192 E.g., a failure to protect health (e.g., right to health, an ESC right) may result in a threat to life (a CP right). See, e.g., CSDH, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, *Commission on Social Determinants of Health - Final Report,* Geneva: World Health Organization 2008; B. Wilson, 'Social Determinants of Health from a Rights-Based Approach', in: A. Clapham & M. Robinson (eds.), *Realizing the Right to Health,* Zurich: Rüffer & Rub 2009, pp. 60-79, p. 60.

193 Vienna Declaration and Programme of Action, UN Doc. A/Conf.157/23, August 1993, § 5 section I.

194 Ibidem supra note 12, J.M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini & H. Fineberg 1999, pp. 7-20, p. 11.

195 The International Bill of Rights consists of the UDHR, ICESCR and ICCPR.

and political rights, such as life, the prohibition against torture.[196] In other words, this means that special attention must be paid to ensure the interdependence of other health-related rights with the right to health and not to conflate their normative framework with that of the right to health and, thereby, deny their distinct content.[197] Moreover, these rights which address integral components of the right to health (i.e., are essential for human health) in conjunction with the right to health oblige States to enhance the health and well-being of individuals (see section 3.2).[198]

At this point, it should be noted that this section does not aim to further elaborate upon all other health-related rights, as it goes beyond the scope of this chapter. Nevertheless, the relevance of such human rights for the enjoyment of the right to health will be further addressed, where relevant, in subsequent chapters as well as a table in Annex 1 gives an overview of several health-related rights.

2.6. CONCLUSIONS

The above analysis of the key formulations of health as a right at the international, regional and national level provides an important insight into the broad notion of the right to the highest attainable standard of health and the state obligations arising from it. It becomes clear that the right to health is a firmly established feature of binding human rights law and is embedded in a significant number of international and regional human rights documents as well as of national constitutions.[199] The depiction of health as a right in the WHO Constitution as well as in Article 12 ICESCR constitutes an expansive framework within which to conceive legislative as well as policy measures for realizing the right to health at national level. Subsequent to the ICESCR other international human rights treaties were adopted like the CRC, the CEDAW, the CRPD, which affirmed and expanded the application of the right to health as it is addressed to different target-groups (i.e., children, women and persons with disabilities etc.). These international human rights documents are relatively more specific in their wording, character and scope than Article 12 ICESCR and as such they provide more protection to the groups concerned than the broadly formulated Article 12 ICESCR. Moreover, at the

196 Ibidem supra note 110, GC No. 14, § 3.

197 Ibidem supra note 11, B.C.A. Toebes 1999, pp. 259-260.

198 Ibidem supra note 110, GC No. 14, §§ 1 & 3.

199 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 60th Sess., Agenda Item 10*, UN Doc. E/CN.4/2004/49/Add.1, 1 March 2004, § 15.

European level, most notably Article 11 (Revised) ESC uses a different terminology than that of Article 12 ICESCR to define the right to health as well as further expands the scope of the right to health by way of an elaborated framework of measures required by States.

However defined (e.g., a 'right to the highest attainable standard of health' or a right to protection of health etc.), the right to health is articulated in most provisions in human rights law which also impose a series of measures on States in order to secure the full implementation of this right. Such measures do not solely focus on obligations concerning access to health care, but range from an obligation to reduce infant mortality to an obligation to develop preventive health care and family planning services, to ensure occupational and environmental health, clean drinking water and adequate sanitation that form the underlying determinants of health. Nevertheless, exceptions in this respect constitute Articles 28, 43 and 45 MWC (at international level) as well as Article 3 of the Biomedicine Convention (at regional level) which only refer to access to health care. Thus, given the broad character of the measures required by States for realizing the right to health there is a need to clarify the type and scope of state obligations in a way to identify practical steps in terms of securing their effective implementation on the part of the States. It is this issue that subsequent chapters seek to address. All in all, despite the recognition of the right to health worldwide, there is still absence of consensus and much confusion exists on the content and implementation of this right due to a lack of conceptual clarity about its meaning and its various aspects under human rights law.

In addition to the treaty provisions, the CESCR and the CRC Committee adopted GC No. 14 (2000) and GC No. 15 (2013) on the right to health, respectively for providing an authoritative explanation of the meaning and implications of Articles 12 ICESCR and 24 CRC, respectively. Meanwhile, at the international level there are several other key international documents that tend to provide an interpretation of and/or are related to the right to health, including declarations, recommendations, plans, and regulations. Such documents have the potential to frame the standards and principles that national health legislation and policies should reflect. Most notably, the International Health Regulations (IHR) adopted by WHO in 2005 acknowledge in a binding manner the significance of human rights protection in case of health emergencies of international concern as well as reflect the general consensus of the international community on the close linkages between health and human rights. As will be elaborately analysed in subsequent chapters, of further importance is that the enjoyment of the right to health is inextricably connected to and reinforced by other rights -civil and

political rights as well as economic, social and cultural rights-which address its integral components.[200]

Finally, the additional value of the right to the highest attainable standard of health as formulated in human rights law is its translation into operational policies, programmes and health-related interventions within countries. Chapter 2 set a platform for further analysis in subsequent chapters of the normative framework of the right to health and its connection to other rights in terms of examining a specific country case study in Part II.

[200] Ibidem supra note 198.

3 Understanding the Content of Health as a Right

3.1. INTRODUCTION

Health is the most significant condition in people's lives. The protection of health implies that all human beings must be safeguarded against potential dangers to their health, in terms of States' taking measures to prevent exposure of individuals to health risks and refraining from acts or omissions of a life-threatening nature, namely detrimental to individual health.[1] A vital part of this issue is to analyze the content of health as *a right to the highest attainable standard of health* ('right to health') through defining its various components, challenges as well as State obligations this right entails towards its effective realization.[2] Thus, understanding the content of health as a right sets limits to its scope and determines what steps are required to realize this right.

The objective of this chapter is to examine the content of the right to health primarily by building, to some extent, upon the previous chapter, i.e., most notably upon a number of key notions from the GCs on the right to health, from which various international standards arise that could regulate the realization of this right. States parties, as primary duty holders, are required to comply with these standards in order to enable the general population and especially vulnerable groups in society to enjoy their right to health effectively. Therefore, an analysis of the definition of health as a right and of the legal state obligations stemming from it will be provided in sections 3.2 and 3.3, respectively. In section 3.4 the progressive nature

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1 World Health Organization, Glossary of Terms, Geneva: WHO 1984, § 30; See, e.g., B.C.A. Toebes, *The Right to Health as a Human Right in International Law,* Antwerp: Intersentia 1999, p. 247; A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, 5, pp. 389-408, p. 394.

2 See, UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN GA, 62nd Sess., Agenda Item 72(b),* UN Doc. A/62/214, 8 August 2007, §§ 70-71.

of state obligations and the concept of core obligations that inform the status and content of the right to health are also discussed. Moreover, after an analysis of the key principles of the right to health in section 3.5, the importance of the right to health indicators and benchmarks will be discussed in section 3.6. In section 3.7, two concepts that challenge one dimension of the right to health will be identified.

3.2. TOWARDS HEALTH AS A RIGHT

As elaborated in chapter 2, health is defined in the preamble of the WHO Constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[3] This concept of health is too broad, in that it is determined not only by biological factors, but also by geographic, cultural and socio-economic factors, whereas its protection requires a wide range of measures, regarding the provision of healthcare, socio-economic measures on poverty reduction, strategies on health promotion etc.[4] As such, health as a right cannot be achieved in isolation from the broader context in which people live and their distinct social characteristics, such as gender, ethnic origin, race etc.[5] Since 1946, health has been proclaimed as a fundamental human right, the right to '*the enjoyment of the highest attainable standard of health'*, an indispensable right for the exercise of other human rights, including the right to life, as pointed out in section 2.5.[6]

Nevertheless, the concept of '*the highest attainable standard of health*' has been a contentious issue ever since its emergence as to how to determine one specific standard universally applicable, given the various levels of development among different countries, regions and health conditions of individuals.[7] Indeed,

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[3] WHO, Constitution of the World Health Organization- adopted by the International Health Conference in New York and was signed on 22 July 1946 by the representatives of 61 states on 22 July 1946, entered into force on 7 April 1948, preamble.

[4] See also earlier scholars, e.g., H.E. Sigerist, *Medicine and Human Welfare*, New Haven/ London: Yale University Press/ Oxford University Press 1941, pp. 53-104.

[5] P. Braveman, 'Social Conditions, Health Equity and Human Rights', *Health and Human Rights* 2010, 12(2), pp. 31-48; B. Toebes, 'The Right to Health', in: Eide, A., Krause, C. and Rosas A.(eds.), *Economic, Social and Cultural Rights: A Textbook*, 2nd Ed., Dordrecht: Martinus Nijhoff Publishers 2001, pp. 169-190, p. 174.

[6] Ibidem supra note 3; V.A. Leary, 'The Right to Health in International Human Rights Law', *Health and Human Rights* 1994, 1(1), pp. 24-56, p. 25; UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000, § 1: 'Every human being is entitled to the enjoyment of the highest attainable standard of health *conducive to living a life in dignity*'. [emphasis added]

[7] See, e.g., supra note 1, B.C.A. Toebes 1999, pp. 16-17 (citing relevant studies); L.O. Gostin,

many scholars have been critical of the right to '*the highest attainable standard of health*'.[8] Griffin, for example, has maintained that 'the highest attainable standard of physical and mental health is not even a reasonable social aim, let alone a right'.[9] Thereto, we need to develop an understanding of the actual meaning of health as a right and of its particular aspects. As such, if we endeavor to clarify the notion of health as a right within the broader context in which it has been proclaimed, it becomes evident that we should begin with an analysis of what this right encompasses. The basic provision in international human rights law with regard to this right is considered to be Article 12 ICESCR[10], as pointed out in section 2.2.1, which stipulates, though, a broad-based right to health and makes no explicit reference to the social well-being. Nonetheless, the definition of health as a right has been affirmed and expanded by a more detailed expression of the children's right to health included in Article 24 CRC and in the non-binding GC No. 15 of the CRC, as observed in sections 2.2.2 and 2.2.4.[11] Additionally, as noted in section 2.2.4, the CESCR in its non-legally binding GC No. 14 provides a detailed and authoritative statement of its understanding of the scope of the right to health contained in Article 12 ICESCR and addresses implementation issues of Article 12 ICESCR with respect to States' obligations.

First of all, as pointed out in chapter 2 the CESCR has emphasized that the right to health is a broad right extending 'not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health'.[12] The aforementioned provision of the GC No. 14 adopts a broad and

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'The Human Right to Health: A Right to the "Highest Attainable Standard of Health' *Hastings Centre Report* 2001, Volume 31, Issue 2, pp. 29-30, p. 29.

8 Ibid.; See, e.g., J.P. Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' *Yale Journal of Law & the Humanities* 2006, Volume 18(2), p. 273-326, p. 273.

9 J. Griffin, *On Human Rights*, Oxford: Oxford University Press 2008, p. 100.

10 As at 30 June 2016, 164 States were parties to the ICESCR. As regards the recognition of health as a right, see chapter 2; Note that Article 12(2) ICESCR outlines a non-exhaustive list of specific steps that States parties should take for the realization of the right to health and for which they can be held accountable (see section 2.2.1.). Ibidem supra note 6, GC No. 14, § 13.

11 As at 30 June 2016, the CRC has been ratified by 196 States.

12 Ibidem supra note 6, GC No. 14, § 11; Note also that as regards to the right to sexual and reproductive health, an integral component of the right to health (§1), the CESCR has adopted

inclusive conception of the content of the right to health.[13] As such, it encompasses a right to access health care (both preventive and curative care) and a right to a set of underlying determinants of health which are largely linked to the so-called 'social determinants' of health and, altogether constitute the general content of the right to health.[14]

In light of the above, the right to health does not directly derive from medical services, but it is closely related to and dependent upon the realization of other human rights (see section 2.5).[15] Nonetheless, the extent to which the right to health encompasses other CP rights as well as other economic, social and cultural rights (ESC rights) is questionable, given the fact that not all of these rights are included in the provisions articulating the right to health.[16]

At the same time, the CESCR has observed that the right to health contains elements that overlap with other human rights. Examples of the overlapping elements of the right to health, which are at the same time enshrined in other discrete provisions of international human rights instruments, are the right to food, the right to housing, the right to safe and healthy working conditions, which are also part

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General Comment No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016.

13 See also UN CRC Committee, General Comment No. 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (art. 24), UN Doc CRC/C/GC/15, 17 April 2013, § 2; See, e.g., the underlying determinants of the right to health: nutrition and housing are contained also in the UDHR, the ICESCR and the CRC. For more details, see B.C.A. Toebes 1999 (supra note 1), Ch V.

14 For instance see, UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 60th Sess., Agenda Item 73(b),* UN Doc. A/60/348, 12 September 2005, § 7. Accordingly, it is stressed that 'There is considerable congruity between the Commission's mandate [on social determinants of health] and the 'underlying determinants of health' dimension of the right to health, as well as other interconnected human rights, such as adequate housing, food and water.'; See also, infra note 15.

15 See, e.g., Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, *Commission on Social Determinants of Health-Final Report,* Geneva, Switzerland: World Health Organization, 2008; B. Wilson, 'Social Determinants of Health from a Rights-Based Approach' in: A. Clapham and M. Robinson (eds), *Realizing the Right to Health*, Zurich: Rüffer and Rub, 2009, pp. 60-79, p. 60.

16 Ibidem supra note 5, B. Toebes 2001, p. 175. It is questionable in that, for example, the action of imposing severe mental or physical suffering on a person even though relates to health, the right to health however does not include a prohibition against torture per se.

of the adequate living conditions.[17] However, such an approach of the CESCR could conduce to the existing conceptual confusion as to the scope of the right to health, as previously mentioned. As such, the view taken here is that the right to health should not be regarded as a repository for everything that covers health, but it should be conceived as a right distinct from the others based on issues explicitly addressed in right to health provisions, such as Article 12 ICESCR, 24 CRC etc.[18]

Meanwhile, the CESCR has also observed that the scope of the right to health entails not only specific entitlements linked to health care and the social determinants of health, but also a set of freedoms relevant to an individual's health. Such freedoms include the right to control one's health and body, involving sexual and reproductive freedom, the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.[19] Hence, from the perspective of the preceding analysis, the right to health includes certain components which are legally enforceable (see sections 2.3.1 and 4.3). All in all, it can be concluded that the interpretative -albeit at a relatively abstract and expanded level at times- approach of the right to health primarily on the part of the CESCR in its GC No. 14 gives rise to several objections as to the meaning and aspects of the right to health within literature, as will be further elaborated in below sections.[20]

3.3. IDENTIFYING THE LEGAL STATE OBLIGATIONS IN RELATION TO A RIGHT TO HEALTH

In order to clarify further the content of the right to health, it is helpful to approach it in terms of state obligations, namely from answering the question on what kind of legal state obligations arise from a right to health. It is well established through the human rights literature that the right to health, like all human rights, depends on States, through playing a role as guarantor of these rights and primary duty bearer.[21] With respect to the right to health, this right primarily obligates States to '*take steps'*

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17 See Annex 1; Ibidem supra note 6, GC No. 14, § 3.

18 Ibidem supra note 1, B.C.A. Toebes 1999, pp. 259-260.

19 Ibidem supra note 6, GC No. 14, § 8; Ibidem supra note 13, GC No. 15, § 24.

20 See, e.g., T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, 30(3), pp. 643-662; E. Riedel, 'The Human Right to Health: Conceptual Foundations' in A Clapham and M Robinson (eds), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 27.

21 See, e.g., Ch. R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, p. 114.

to ensure the highest possible level of health for all.[22] It is within this context that for instance several human rights bodies have adopted the so called 'tri-partite typology' of the content of human rights (social or classical) the most well-known practical and analytical tool established by Asbjørn Eide in 1987 and rooted in the work of Henry Shue (1980).[23] On the basis of this typology the CESCR establishes three levels of protection for the right to health and consequently three types of States' commitments, in order to implement the right to health at the national level, namely the obligations to *respect*, to *protect* and to *fulfill,* which is extended by the Committee to include 'obligations to facilitate, provide and promote'.[24] Additionally, the CESCR in its GC No. 14 provides examples in an attempt to specify the scope of these legal state obligations in relation to the right to health. In terms of such effort, the Committee formulates also possible violations of the right to health in relation to the three aforementioned obligations (i.e. occurring in case of non-compliance with these obligations), illustrated with a number of examples in its GC No. 14.[25]

At a primary level is the obligation to *respect,* a negative obligation, which implies that States must refrain from interfering directly or indirectly with the enjoyment of the right to health.[26] According to the CESCR, the obligation to

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22 See, e.g., Article 12 ICESCR & Article 24 CRC.

23 UN, *The New International Economic Order and the Promotion of Human Rights: the Right to Adequate Food as a Human Right*, *Report of the Special Rapporteur, Asbjørn Eide, UN ESCOR, Commission on Human Rights, Sub-Commission on the Prevention of Discrimination and Protection of Minorities, 39th Sess., Agenda Item 11*, UN Doc. E/CN.4/Sub.2/1987/23, 7 July 1987, §§ 66-69; H. Shue, *Basic Rights: Subsistence, Affluence and US Foreign Policy*, Princeton, New Jersey: Princeton University Press 1980, p. 52 et. seq. He suggested three types of duties: to avoid depriving, to protect from deprivation and to aid the deprived; Ibidem supra note 6, UN CESCR, GC No. 14, § 33; In addition to the GC No. 14, this typology has been applied by respective bodies in a number of other authoritative sources, such as the GC No. 12 on the right to food, UN Doc. E./C.12/1995/5, 12 May 1999, the GC No. 15 on the right to water, UN Doc. E/C.12/2002/11, 20 January 2003, Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, UN Doc. E/C.12/2000/13, 2 October 2000, § 6, General Recommendation No. 24 (CEDAW) and GC No. 15 of the CRC Committee on the right to health of the child (supra note 13) etc. A version of this typology (i.e. to respect, to protect, to promote and to fulfil) is adopted also in the 1996 Constitution of the Republic of South Africa (as amended up to 2012), namely in Article 7(2).

24 Ibidem supra note 6, GC No. 14, § 33; Note that the CESCR applies partly the 'tripartite typology' to identify state obligations at the international level too (see, GC No. 14, § 39 and section 4.4.).

25 Ibid., § 49 read in conjunction with §§ 34-36; Examples of violations of these obligations are mentioned in GC No. 14 (supra note 6), §§ 50-52.

26 Ibidem supra note 6, GC No. 14, §§ 33-34.

respect requires State parties to refrain from , *inter alia*, 'denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices …'.[27] Additionally, in the context of the obligation to *respect*, States should respect choices concerning health and health care, namely refraining from, *inter alia*, engaging in forced sterilization and applying coercive medical treatments, from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs.[28]

At a secondary level, the obligation to *protect,* a positive obligation, requires States to take measures to prevent third parties, such as private parties (corporations, employers, doctors etc.) from interfering with Article 12 guarantees and from the infringement of an individual's right to health (see also section 3.7.1).[29] The protection of the enjoyment of the right to health includes the adoption and enforcement of laws or other measures by the States, concerning the health of the population within the States' jurisdictions.[30] For example, pursuant to GC No. 14, States should, *inter alia,* ensure that 'privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services'; 'control the marketing of medical equipment and medicines by third parties'; 'take measures to protect all vulnerable or marginalized groups of society'.[31]

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[27] Ibid., § 34; Note also that the principle of non-discrimination is explicitly enforced by Article 2(2) ICESCR which prohibits discrimination of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, in the enjoyment of the rights enunciated in ICESCR.

[28] Ibidem supra note 6, GC No. 14, § 34.

[29] Ibid., § 33.

[30] Ibid., §§ 51 and 35.

[31] Ibid., § 35; Note also that when it comes to public health hazards, in terms of the obligation to *protect* the health of the general population (i.e. public health), a tension between the right to health within this context and the CP rights of individuals, such as the rights to privacy, physical integrity and liberty, can be created due to a State's choice of implementing severe health state measures, such as forcible HIV testing, arbitrary detention measures (Ibid., § 28). Nevertheless, certain requirements must be satisfied in terms of imposing limitations, as follows: 'Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. (…)Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society'. [emphasis added] read in

At a tertiary level, the obligation to *fulfill,* a positive obligation, which includes the 'obligations to facilitate, provide and promote', requires States to recognize the right to health in their political and legal systems by adopting appropriate legislative, administrative, budgetary, judicial, promotional and other measures.[32] This entails, *inter alia*, the effective monitoring of the realization of the right to health at the national level, the equitable distribution of health facilities among the population, the provision of a percentage of the available budget to health and the adoption of a national health policy with a detailed plan for realizing the right to health.[33] Hence, States are obliged to create conditions under which sufficient access to health care will be provided to individuals, as well as to ensure access to the underlying determinants of health, such as clean drinking water, adequate sanitation.[34]

Last but not least, in light of the preceding analysis of the tripartite typology of State obligations as advanced by the CESCR in relation to the right to health, the following four observations are made. First, the CESCR does not explain in detail practical oriented measures required by States under this typology of obligations. Instead, there is a high level of abstraction in the text of these obligations in relation to the right to health, which may contribute to an overlap between these obligations, as will be elaborated further below. Second, this typology, despite its general content as defined by the CESCR, can perhaps be a functional tool by which to further define the scope of the right to health and the type of measures required by States for its effective implementation.[35] Third, not all three obligations are concerned with the need to allocate the resources available within a State for the effective implementation of the right to health. For example, the content of the obligation to *respect* does not entail budgetary considerations. On the contrary, it requires States to abstain from interfering with the enjoyment of the right to health, namely from acting.[36] Similarly, the obligation *to protect* requires States to regulate the impact of non-State actors upon individuals' health which does not necessarily involve costs and have financial implications for States.

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conjunction with the limitation clause under Article 4 ICESCR.; Due to space constraints, for an elaborate analysis: as regards to human rights standards, see, B. Toebes, 'Human rights and public health: towards a balanced relationship' *The International Journal of Human Rights* 2015, Volume 19, No. 4, pp. 488-504, p. 500 and as regards to national implementation, see, the case study in Part II section 7.4.2.

32 Ibidem supra note 6, GC No. 14, §§ 33 and 37 and §§ 53-56.

33 Ibid., §§ 36 and 52.

34 Ibid.

35 See supra note 23 regarding the use of this typology within the UN human rights system; Ibidem supra note 1, B.C.A. Toebes 1999, p. 311

36 Ibid., B.C.A. Toebes 1999.

Fourth, an overlap between the three categories of State obligations of the typology can be discerned. In particular, an overlap can be found between the content of the obligation to *protect* and the content of the obligation to *fulfill*, as both obligations require States to act and take steps. As such, in academic literature, Koch, for instance, has criticized the application of the so-called 'tri-partite typology of States' obligations'. She argues that even though the typology elaborates on the normative character of human rights obligations, the distinction between the tripartite obligations is not always clear '… as we move from the obligation to respect, through the obligation to protect, to the obligation to fulfil seems to work much better in theory than in practice: confronted with complexity of real life the various obligations are hard to distinguish from one another'.[37] The overlap between the obligations results in the interdependence of duties, which indicates that human rights cannot be fully realized by performing only one of the types of obligations they impose.[38] This might explain why for instance the CESCR makes frequent and general reference to this typology in its Concluding Observations.[39] From the perspective of the aforementioned, without undermining the importance of the tripartite typology of State obligations in relation to defining the scope of the right to health and the obligations arising from it, there is therefore a need for more conceptual clarity as to its content in relation to the right to health. An explicit textual basis is required to support its application and utility by which the relevant human rights monitoring bodies can hold States accountable.

3.4. PROGRESSIVE NATURE AND CORE OBLIGATIONS

Unlike CP rights, such as the right to life, ESC rights are to be progressively realized within the States' maximum available resources, as embedded in Article 2 § 1 ICESCR.[40] Article 2 § 1 ICESCR sets out the principal obligations of States with

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37 I.E. Koch, 'Dichotomies, Trichotomies or Waves of Duties?', *Human Rights Law Review* 2005, 5(1), pp. 81-103, p. 92.

38 Ibid., p. 91.

39 See, for a general reference to the tripartite typology e.g., UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 8; See, M. Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Antwerp: Intersentia, 2003, p. 210; Ibidem supra note 37.

40 Article 2 ICCPR (GA Res. 2200A (XXI), 1966) stresses that each State party 'undertakes to take the necessary steps (…), to adopt such legislative or other measures as may be necessary to give effect to the rights recognized'. The respective provision encompasses an immediate obligation to respect and ensure all rights recognised in the ICCPR; Article 2 § 1 ICESCR (GA Res. 2200A (XXI), 1966).

regard to the rights subsequently included in ICESCR and is of fundamental importance for the Covenant, as it defines its scope within the human rights practice.[41] Nevertheless, this provision is surrounded with great ambiguity with respect to its implementation. Most illuminating, in scholarly writings, is the argument that Article 2 § 1 ICESCR is 'a fairly unsatisfactory article, with its convoluted phraseology in which clauses and sub-clauses are combined together in an almost intractable manner, making it virtually impossible to determine the precise nature of the obligations'.[42]

Hence, given this ambiguity, at the UN level, attempts have been made to clarify the meaning of the aforementioned provision and its implementation issues by the treaty monitoring body of the ICESCR, namely the CESCR (see section 4.2.1). As regards the right to health, the CESCR in its authoritative source, GC No. 14, by using the clause of progressive realization recognizes the fact that the right to health cannot be achieved immediately or in a short period of time, but rather its realization is a continuing process subject to a State's available resources.[43] However, this policy freedom given to States could lead to misunderstandings in that States could claim that they are not obliged to ensure any given level of protection of this right and excuse their failure to take steps based on the assertion of lack of economic growth and of insufficient national resources.[44] To avoid this misinterpretation on the part of the States, the CESCR has set a number of limitations on this wide margin of discretion in virtue of the progressive nature of the right to health. Particularly, the Committee has explained that the concept of progressive realization 'should not be interpreted as depriving States parties' obligation of all meaningful content', namely the minimum subsistence of the right to health, also known as its core content, as will be elaborated below.[45] On the contrary, States are obliged to move as expeditiously and effectively as possible

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41 Br. Griffey, 'The "Reasonableness" Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights', *Human Rights Law Review* 2011, 11(2), pp. 275-327, p. 280.

42 M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, p. 151.

43 Ibidem supra note 6, GC No. 14, § 31; See, UN CESCR, General Comment No. 3: *The Nature of State Parties' Obligations*, UN Doc E/1991/23, 14 December 1990, § 9.

44 J. Asher, *The Right to Health: A Resource Manual for NGOs*, London, UK: Commonwealth Medical Trust 2004, p. 23.

45 Ibidem supra note 6, GC No. 14, § 31; See, other authoritative sources, e.g., The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, *NQHR* 1997, 15(2), pp. 244-252. Pursuant to Guideline 8 the State cannot use the 'progressive realization' provisions as a pretext for non-compliance.

by taking deliberate, concrete and targeted steps and by guaranteeing the principle of non-discrimination.[46] In other words, while taking into account resource availability and progressive nature of the right, States must show the extent of the level of protection for the right to health in their countries respectively, which is an immediate obligation of the States parties, through careful planning and by priority setting.[47]

The Committee has further explained that it is not permissible for States based on the requirement to use the maximum of available resources in the implementation of the right to health, to take retrogressive measures, namely to lean back with respect to the protection of the right, that will undermine the realization of the right to health.[48] Note by way of example that the second Special Rapporteur on the Right to Health (Anand Grover) has underlined that the limitations on the health care benefits due to the economic crisis are in contrast to State obligation to refrain from taking retrogressive measures that impact on health.[49] This implies that States are required to use effectively their available (limited) resources in terms of responding to the needs of their populations within their jurisdictions (see section 4.2). In case of adoption of any deliberately retrogressive measures on the part of a State, such as a reduction in its expenditures, the Committee in its GC No. 14 has argued that the State has the burden of proving that such measures have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in ICESCR in the context of the full use of the State's maximum available resources.[50] Nonetheless, the Committee's approach is quite ambiguous as regards to the evaluation of the State's aforementioned course of action in relation to the right

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[46] Ibid., GC No. 14 (supra note 6), §§ 30-31; See, other authoritative sources, e.g., Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN ESCOR, 4th Comm, 43rd sess, Annex, UN Doc. E/CN.4/1987/17, § 21 (a reference to the State obligation to move expeditiously towards the realization of ESC rights is made).

[47] Ibid., GC No. 14, § 30; See, other authoritative sources, e.g. Limburg principles (supra note 46), § 23 and 28; Ibidem supra note 20, E. Riedel 2009, pp. 21-39, p. 30.

[48] Ibidem supra note 6, GC No. 14, § 32; Ibidem supra note 39, M. Sepúlveda, p. 323.

[49] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN HRC, 23rd Sess., Agenda Item 3,* UN Doc. A/HRC/23/41, 15 May 2013, § 38.

[50] Ibidem supra note 6, GC No. 14, § 32; Ibidem supra note 43, GC No. 3, § 9; The CESCR has suggested a number of criteria by which to evaluate the adoption of retrogressive measures under the justification of resource constraints on the part of a State, such as a reduction in expenses, see section 4.2.1 (b).

to health, given that the Committee has not specified any practical oriented guidelines as to the precise course to be taken by States within their jurisdictions.[51]

Besides the obligation of the States to progressively realize ESC rights, including the right to health, the CESCR has suggested that States parties have a 'core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant ...', which form part of the core content of these rights.[52] As regards the definition of such obligations in relation to the right to health, GC No. 14 based on the Programme of Action of the International Conference on Population and Development (ICPD 1994) and the Primary Health Care Strategy of the Alma Ata Declaration (WHO 1978) is the first document that attempts to define indirectly the minimum essential level of the right to health, namely the core of this right, framed in terms of core obligations for States.[53] These core obligations could be used as a means of pressure on States in order to comply with their treaty obligations. For example, such obligations could probably play a role with the definition of minimum health services that have to be available during a severe economic crisis to marginalized population groups without financial means, such as undocumented migrants, and be prioritized in the allocation of scarce resources (see Part II, chapter 7).[54] The GC No. 14 indicates that the core state obligations encompass both the minimum essential levels of health care (i.e., immunization against major infectious diseases, provision of essential drugs, maternal and child health care) and of the underlying determinants of health (i.e., minimum essential food, housing, sanitation, access to information regarding main health problems); altogether partly cover the content of primary health care (i.e. certain essential elements), as defined in the Declaration of Alma-Ata, notably as part of a comprehensive national health system.[55] Of note,

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[51] See also, for a similar statement supra note 42, M.C.R. Craven 1995, pp. 132 and 134.

[52] Ibidem supra note 6, GC No. 14, §§ 43- 44 read in conjunction with GC No. 3 (supra note 43), § 10.

[53] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 62nd Sess., Agenda Item 72(b),* UN Doc A/62/214, 8 August 2007, § 28.

[54] See for a general argument, B. Toebes, 'The Right to Health and Other Health-Related Rights' in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 83-110, p. 100.

[55] Ibidem supra note 52; Declaration of Alma-Ata (1978) adopted by the International Conference on Primary Healthcare, Alma-Ata, USSR, September 6-12, §§ VI-VIII; Of note, similar to the meaning of the core content of the right to health, WHO has simply stressed that 'there is a [health] baseline below which no individuals in any country should find

in 2013 the CRC Committee in its GC No. 15 adopted a similar attitude towards the definition of the core content of the right to health of the child framed in terms of core state obligations.[56]

The right to health without the aforementioned core obligations would be deprived of its raison d'être[57] and would lose its significance, and for that reason these core obligations are not subject to progressive realization even in times of resource constraints.[58] In other words, even in the presence of limited resources these core obligations constitute the minimum level of entitlements of the general content of the right to health that States must respect and guarantee irrespective of the availability of resources.[59] As such, the CESCR in GC No. 14 argues that the obligations concerning the core content of the right to health are non-derogable (i.e. not to be restricted in any way, for instance due to scarce resources).[60] Nevertheless, this CESCR approach (i.e., the disassociation of the core content of the right to health from a State's available resources) is contrary to an earlier approach adopted in its GC No. 3, where the Committee establishes a connection between the available resources and the discharge of core obligations.[61] Thereto,

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themselves' (WHO, *Global Strategy for Health for All by the Year 2000,* Geneva: WHO, 1981, Ch.II, p.31, § 1 - Adopted in WHO Resolution WHA 34.36); Note that the concept of primary health care is embraced in CESCR's guidelines addressed to the States for the preparation of their reports under the ICESCR, in general, and specifically under Article 12 ICESCR (UN CESCR, Guidelines on Treaty-Specific Documents to be submitted by the States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/C.12/2008/2, 24 March 2009, Annex, § 55).

56 Ibidem supra note 13, GC No. 15, § 73; The CRC in Article 24 § 2 (b) and (c) puts emphasis on the development of primary health care.

57 Ibidem supra note 43, GC No. 3, § 9. Accordingly, it is stressed that the raison d'être of the Covenant 'is to establish clear obligations for States parties in respect of the full realization of the rights in question'.

58 Ibidem supra note 43, GC No. 3, § 10. It reads as follows: '…the Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant…'; Ibidem supra note 1, B.C.A. Toebes 1999, p. 244.

59 Ibid., read in conjunction with GC No. 14 (supra note 6), § 30; Ibidem supra note 1, B.C.A. Toebes 1999, p. 295.

60 Ibidem supra note 6, GC No. 14, § 47.

61 Ibidem supra note 43, GC No. 3, § 10. It reads as follows: 'it must be noted that any assessment as to whether a State has *discharged its minimum core obligation* must also *take account of resource constraints* applying within the country concerned'. [emphasis added]

this contradiction is indicative of the confusion that exists around the nature of state (core) obligations in relation to the right to health. Last but not least, as regards the adoption of retrogressive measures on the part of a State as mentioned before, the CESCR has suggested that in case these measures are incompatible with the core obligations under the right to health, namely the core content of the right to health is affected, this should be seen as a (potential) violation of the right to health (see Part II, section 6.4).[62]

From the perspective of the above analysis, the following observations are made which altogether make clear that there is an absence of worldwide consensus on the progressive nature and core content of the right to health. Due to the open-ended character of progressive realization of the right to health, the CESCR has attempted to clarify -albeit at a relatively general level at times- its core content in terms of identifying a number of core obligations arising from this right to be met under all circumstances. As such, one may argue that progressive realization of the right to health, namely of its remaining section, starts from the point where the core of the right has been achieved. Nevertheless, significant work remains to be done on this area and the Committee's attempt has been the issue of extensive discussion among legal scholars.[63] Toebes, for instance, has underlined the general character of several core obligations, such as 'access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalised groups', which gives little precise direction to States as regards to their application.[64] In addition, concern has been expressed at that 'the definition of core content poses the danger that the remainder of a right is subsequently considered unimportant and therefore may well be denied'.[65] Such an approach is based on Article 2 § 1 ICESCR pursuant to which States are required to progressively realize the rights enshrined in ICESCR and to the maximum of their available resources. This implies that the realization of the core of a right is not, by itself, sufficient; States have another task that of striving to realize the full spectrum of that right and not denying it as soon as that minimum standard

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62 Ibidem supra note 6, GC No. 14, § 48.

63 See, e.g., B. Toebes 2001 (supra note 5); K.G. Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' *The Yale Journal of International Law* 2008, Volume 33, pp. 113-175, p. 154; J. Tobin, *The Right to Health in International Law*, Oxford: Oxford University Press 2012, pp. 239-243.

64 B. Toebes, 'The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands' *Health and Human Rights* 2006, Volume 9 (1), pp. 103-127, p. 117; Ibidem supra note 6, GC No. 14, § 43(a).

65 Ibidem supra note 5, B. Toebes 2001, p. 176.

of health (i.e., its core) has been achieved.[66] Moreover, the very expansive definition of non-derogable minimum core obligations irrespective of available resources advanced by the CESCR is contested in literature in that their application in practice by States is well-connected to the requirement of available resources without further considering the diverse economic realities and capacity among States to this end.[67]

On the other hand, other academic commentators have argued that the content of a right should not be considered as definite as this evolves over the years.[68] In connection to the above argument, another concern that has been expressed is as to how to determine a specific core content of a right when there is a variance in resources and in the level of development among the countries, as well as in health needs.[69] This might be the reason, for instance, why some courts have not applied this concept in their decisions.[70] Overall, caution must be exercised with respect to the precise definition and implementation of this controversial concept. Such a concept deserves further scrutiny by taking into account national circumstances and different health needs of individuals and groups, without though being strictly dependent on such situational circumstances, as this could refuse the universal character of human rights.[71] In this regard, of particular assistance could be the development and use of indicators (see below section 3.6). Yet, whatever the extent of controversy exists in relation to the progressive nature and core content of the right to health, the primary importance of the core concept should not be overlooked as regards the prioritization and satisfaction on the part of the State of the basic

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66 Ibid.; F. Coomans, *Identifying the Key Elements of the Right to Education: A Focus on its Core Content*, London: Child Rights International Network 2007, p. 2 (www.crin.org).

67 See, e.g., Ibidem supra note 63, J. Tobin 2012, p. 98.

68 Ibidem supra note 1, B.C.A. Toebes 1999, p. 288 (citing relevant studies).

69 Ibidem supra note 5, B. Toebes 2001, p. 184 (citing relevant studies); P. Hunt & G. Backman, 'Health Systems and the Right to the Highest Attainable Standard of Health', *Health and Human Rights* 2008, 10(1), pp. 81-92, p. 85 (also found in: UN Doc. A/HRC/7/11, § 52). It is noted by way of example that in some countries the health challenge is undernutrition, whereas in other countries it is obesity.

70 See, e.g., the decision of the South African Constitutional Court in *Minister of Health and Others v. Treatment Action Campaign and Others*, Case No: CCT 8/02, 5 July 2002. The Court rejected the definition of a minimum core standard for the right to health by stating that 'All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis.' (§ 35)

71 Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna on 25 June 1993, Part I, § 5; An analogous approach was adopted as regards to the core content of the right to education, see supra note 66, F. Coomans.

and pressing health needs of vulnerable population groups, including Roma children and undocumented migrants (see section 4.2).

3.5. KEY PRINCIPLES

The normative content of the right to health, notably to health care, was interpreted by the CESCR from the angle of four interrelated and essential elements, *Availability*, *Accessibility*, *Acceptability* and *Quality* (the so-called '*AAAQ'*) that apply with regard to all health-related services.[72] Of note, the 'AAAQ' were subsequently recognized by the CRC Committee and also included in its GC No. 15 on the right to health of the child.[73] The '*AAAQ*' together with the tripartite typology of States' obligations to *respect*, to *protect* and to *fulfill*, as examined above, can be useful tools in that they can offer a framework of what the right to health includes and what steps are required by States towards its the effective realization. In the subsequent paragraphs the four key principles of the right are set out. Note that the 'AAAQ' will be addressed in Part II, in the interpretation of State obligations with respect to the right to health (care), namely within a domestic health care law context (see Chapter 6, section 6.4).

With regard to *availability*, the CESCR has indicated that health facilities, goods and services must be available in sufficient quantity given the State's developmental level.[74] Although the precise nature of these facilities and services varies between the States, the CESCR has explained that these include, *inter alia,* hospitals, clinics, trained health personnel, essential medicines according to the WHO Essential Drugs List, preventive public health strategies and health promotion activities as well as the underlying determinants, such as safe drinking water and adequate sanitation facilities. Note that this is an expansive list of services, which depends on the progressive nature of a State's obligation to realize the right to health- the meaning of which was discussed previously (see section 3.4).[75]

In relation to *accessibility*, the CESCR has indicated that accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic

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[72] Ibidem supra note 6, GC No. 14, § 12; Likewise, several comparable principles are found in UN GCs on substantive rights in ICESCR, including the UN GC on the right to education (UN Doc. E/C.12/1999/10), water (UN Doc. E/C.12/2002/11) and food (UN Doc. E/C.12/1995/5).

[73] Ibidem supra note 13, GC No. 15, §§ 112-116; Of note, the 'AAAQ' structure was also adopted by the CRC Committee in its GC No. 4: Adolescent Health and Development in the Context of the CRC, UN Doc. CRC/GC/2003/4, 1 July 2003, § 41.

[74] Ibidem supra note 6, GC No. 14, § 12(a).

[75] Ibid.; Ibidem supra note 20, E. Riedel, p. 28.

accessibility (affordability) and information accessibility.[76] The non-discrimination dimension in accessibility requires that all health services must be accessible to everyone without discrimination, 'especially the most vulnerable or marginalized sections of the population in law and in fact'.[77] By way of example, as regards the identification of vulnerable groups the CESCR has explained that the ICESCR under respective provisions grants specific protection against discrimination in access to health care and underlying determinants of health on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status.[78] In light of the above, it can be discerned that the danger of applying discriminatory practices in a right to health context can be particularly high concerning groups such as women, children, undocumented migrants, members of ethnic minorities and people with a poor health status. In addition to the CESCR, the significance of non-discrimination in a health care context has been recognised and endorsed in various documents of human rights committees and institutions. For instance, the Parliamentary Assembly of the CoE in its recommendation has remarked that '… the main criterion for judging the success of health systems reforms should be effective access to health care for all without discrimination, which is a basic human right. This also has the consequence of improving the general standard of health and welfare of the entire population'.[79] As such, the principle of non-discrimination can function as a yardstick to measure States' compliance with their right to health obligations while ensuring that this principle is integrated into national health law-policy making.

Additionally, all health services must be physically and economically accessible.[80] This means, *inter alia*, that they must be accessible for all sections of the population, especially for the most vulnerable groups (i.e., ethnic minorities, indigenous people, women, children, older persons, persons with disabilities etc.).[81]

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[76] Ibidem supra note 6, GC No. 14, § 12(b).

[77] Ibidem supra note 6, GC No. 14, § 12(b). Note also that several other international conventions, including the CRPD (Article 25f), the ICERD (Article 5(e)(iv)), the MWC (Article 25(1)), the CEDAW (Articles 12(1)-(2), 14(b)), have specific provisions with regard to the protection of individuals from discrimination while accessing health services.

[78] Ibidem supra note 6, GC No. 14, §§ 18-19.

[79] Recommendation 1626 of the Parliamentary Assembly of the Council of Europe on 'the reform of health care systems in Europe: reconciling equity, quality and efficiency', 1 October 2003, § 4.

[80] Ibidem supra note 6, GC No. 14, § 12(b).

[81] Ibid.

For instance, in order to secure physical accessibility for persons with disabilities, health care should be provided within safe reach (e.g., local health centers, mobile outreach health care units, available and accessible transport etc.) and should be physically accessible (e.g., existence of ramps, lifts, etc.).[82] At the same time, the issue of economic accessibility (affordability) is also of high importance, as health services, including drugs, must be based on the principle of equity, ensuring that those in need and especially the poorer households are not disproportionately burdened with health expenses compared with richer households.[83] In addition to the GC No. 14 of the CESCR, economic accessibility is considered of importance in various other human rights documents. The CRC Committee, for instance, in its non-binding GC No. 15 elaborates on this principle by calling on States 'to abolish user fees and implement health-financing systems that do not discriminate against women and children on the basis of their inability to pay'.[84] Furthermore, in a binding manner Article 13 § 1 (Revised) ESC provides that the State has 'to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition'.[85] Moreover, accessibility includes the right to seek, receive and impart information on health issues, involving treatment options, health status and health promotion, without at the same time impeding medical confidentiality.[86]

With respect to *acceptability*, the CESCR has broadly underpinned that all health facilities, good and services must be, *inter alia*, respectful of medical ethics and culturally appropriate and gender-sensitive, as well as designed to respect confidentiality and improve the health status of those served.[87] Finally, the *quality* of health services is a significant factor in their delivery. The CESCR has explained that health services must be scientifically and medically appropriate and of good quality (e.g., skilled medical personnel, unexpired drugs etc.).[88] In addition to the

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[82] See, e.g. UN CRC Committee, GC No. 15 (supra note 13), § 114(b); Article 25(c) CRPD, UN Doc. A/RES/61/106; Ibidem supra note 55, UN CESCR, UN Doc E/C.12/2008/2, Annex, § 56(a).

[83] Ibidem supra note 6, GC No.14, § 12(b); Ibidem supra note 55, UN CESCR, UN Doc E/C.12/2008/2, Annex, §§ 56(b), 57(f).

[84] Ibidem supra note 13, GC No. 15, § 114(c).

[85] ESC, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) ESC, 3 May 1996, entered into force 1 July 1999, ETS 163.

[86] Ibidem supra note 6, GC No. 14, § 12(b); Ibidem supra note 13, GC No. 15, § 114(d).

[87] Ibid., GC No. 14, § 12(c); Ibidem supra note 13, GC No. 15, § 115.

[88] Ibid., GC No. 14, § 12(d).

CESCR, the principle of quality has been further addressed and expanded by other human rights bodies. The CRC Committee elaborately discusses in its GC No. 15 the principle of quality in relation to the right to health of the child in that it requires that (1) medical personnel are skilled and adequately trained to care for all children, (2) hospitals' equipment is scientifically approved and appropriate for all children, (3) drugs are scientifically approved, unexpired, monitored for negative side-effects and are child-specific (where necessary).[89] Moreover, in the context of the CoE and its reporting procedure, the European Committee of Social Rights (ECSR), the treaty monitoring body of the (Revised) ESC, in its 'Conclusions' has paid attention, *inter alia*, to life expectancy, rates of mortality and waiting lists which are indicative of the quality of health care in a given country.[90]

Last but not least, the CESCR has also noted -albeit at a relatively high level of abstraction- that the precise application of the 'AAAQ' 'will depend on the conditions prevailing in a particular State party'.[91] As such, this general statement of the CESCR might allude that States enjoy a high level of policy freedom in the practical application of the 'AAAQ' by taking into account their national characteristics and diverse health needs of individuals and groups within their jurisdiction. Arguably, the open-ended content of the 'AAAQ' affirms that the content of the right to health, like other human rights, is not definite, but rather evolves to be responsive to characteristics and needs of individuals over time (see section 3.4).[92] Thereto, one may argue that the 'AAAQ' are universally applicable in virtue of their open-ended content and can be utilized as a practical framework for all State actions towards realizing the right to health. Such policy freedom, though, is subject to the overall requirement that whatever measures adopted by States these must contribute to the effective realization of the right to health within their jurisdiction.[93]

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89 Ibidem supra note 13, GC No. 15, § 116.

90 The ECSR examines states' reports and decides whether or not the situations in the states concerned are in conformity with the (Revised) ESC. Its decisions are known as 'Conclusions'. See, e.g., ESC, ECSR: Conclusions XIX-2 (2009) Greece; XIX-2 Germany (2009); Lithuania (2009); Council of Europe Committee of Ministers, Recommendation No. R(99) 21 of the Committee of Ministers to Member States on criteria for the management of waiting lists and waiting times in health care, 30 September 1999, §§ 3, 12; For a similar approach, see, M. San Giorgi, *The Human Right to Equal Access to Health Care*, Cambridge/Antwerp/Portland: Intersentia 2012, p. 60.

91 Ibidem supra note 6, GC No. 14, § 12.

92 Ibidem supra notes 68 and 69, as regards the evolving character of human rights, like the right to health.

93 See, e.g., UN CESCR, General Comment No. 9: *The Domestic Application of the Covenant*, 3 December 1998, UN Doc E/C.12/1998/24, § 5.

In addition to the 'AAAQ', accountability and participation ('AP'), although not part of the 'AAAQ', are considered to be important elements of the right to health by human rights bodies. Both the CESCR and the CRC Committee in their GCs on the right to health mention these two notions either implicitly or explicitly in relation to the effective enjoyment of the right to health by every individual.[94] Increasingly though, these two additional notions are being extensively discussed in health and human rights literature for their importance in relation to the right to health (see below). Potts in her comprehensive analysis on accountability and the right to health explains that accountability is a process which requires governments to show, explain and justify how they have fulfilled their obligations with respect to this right.[95] She also identifies four essential components of an effective accountability process: monitoring, accountability mechanisms, remedies and participation.[96] Similarly, Hunt and Backman hold that institutional and systematic accountability are connected to effective monitoring.[97] Meanwhile, the accountability mechanisms can be judicial, quasi-judicial (e.g., national human rights institutions), administrative (e.g., human rights impact assessments), political (e.g., parliamentary review) or social (e.g., involvement of the civil society).[98] Finally, Potts elaborates on the meaning of participation for the right to health. Accordingly participation implies that society has an active role in all health-related decision-making that affects them.[99] Likewise, Hunt defines participation as 'a vital feature' of the right to health, in that this right 'not only attaches importance

[94] See, e.g. with respect to the notion of accountability: UN CESCR, GC No. 14 (supra note 6), § 55 and 59 (emphasis on legal accountability); UN CRC Committee, GC No. 15 (supra note 13), § 90; See, e.g. with respect to the notion of participation: UN CESCR, GC No. 14 (supra note 6), §§ 11, 17 (political participation), 34 and 54; UN CRC Committee, GC No. 15 (supra note 13), §§ 19, 64 and 108 and GC No. 12 on the right of the child to be heard UN Doc. CRC/C/GC/12, 20 July 2009, § 3; Note that the importance of community participation is one of the main subjects addressed in the Declaration of Alma-Ata (supra note 55), §§ IV, VI and VII; See also section 4.2.3., both notions are elaborately discussed by the consecutive Special Rapporteurs on the Right to Health.

[95] H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health.* University of Essex: Human Rights Centre 2008, p. 13. <http://www.essex.ac.uk/human_rights_centre/research/rth/projects.aspx>

[96] Ibid.

[97] Ibidem supra note 69, P. Hunt & G. Backman, p. 87.

[98] Ibidem supra note 95, p. 17.

[99] H. Potts, *Participation and the Right to the Highest Attainable Standard of Health.* University of Essex: Human Rights Centre 2009, p. 15. <http://www.essex.ac.uk/human_rights_centre/research/rth/projects.aspx>

to reducing the burden of ill health, it also emphasises the importance of democratic and inclusive processes by which this objective is to be achieved'.[100] However, Baxi, legal scholar, has criticized the concept of participation as bypassing some further hard problems related to those who are incapable of meaningful participation, due to their status or situation (physical impairment).[101] Such comments reflect the need for caution on the part of the States to strike an appropriate balance between the needs and interests of intended beneficiaries and all other individuals or groups in a way that the needs of all others are not overlooked and/or displaced when determining health priorities.

3.6. INDICATORS AND BENCHMARKS

Given the progressive nature of the right to health, methods and techniques have been considered that 'deepen' the understanding of this right and assist in measuring a State's progress with regard to its effective realization over time.[102] In particular, the variance in the existing socio-economic conditions and the diverse health needs within different countries have resulted in developing indicators and benchmarks (self-set targets to be achieved in future time[103]) to facilitate the task of application of the concept of progressive realization as well as of the satisfaction of core obligations of the right to health in different countries.

Within the UN human rights system, given the existence of different conditions in several countries at different times, human rights monitoring bodies have encouraged States to identify indicators and related national benchmarks in relation to the right to health. The CESCR, for instance, in its GC No. 14 has indicated its intention to collaborate with States during their periodic reporting process on 'the scoping' of indicators and benchmarks designed to their specific situations.[104]

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100 P. Hunt, *Some Closing Remarks on Participation and the Right to the Highest Attainable Standard of Health*, Third National Health Conference, Peru: Civil Participation and the Right to Health, 11-12 July 2006, p. 1. <http://repository.essec.ac.uk/9800/1/closing-remarks-on-participation-right-highest-attainable-standard-health-pdf>; See also, section 4.2.3.

101 U. Baxi, 'Place of the Human Right to Health and Contemporary Approaches to Global Justice', in: J. Harrington and M. Stuttaford (eds.), *Global Health and Human Rights*, London and New York: Routledge 2010, p. 18.

102 See, e.g., Reports of the Special Rapporteur on the Right to Health (infra note 109); Economic and Social Council, Report of the High Commissioner for Human Rights on the Implementation of Economic, Social and Cultural Rights, UN Doc. E/2009/90, 8 June 2009, § 8.

103 Ibidem supra note 44, J. Asher 2004, p. 89.

104 Ibidem supra note 6, GC No. 14, § 58; Ibidem supra note 55, UN Doc. E/C.12/2008/2, Annex § 3(b).

Nevertheless, the CESCR in its authoritative source for the right to health makes only a simple and general reference to the need for indicators and benchmarks and places the responsibility of identifying them on States by providing that 'national health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the state party's obligations under article 12…' [105] 'Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator…'.[106] Similarly, the CRC Committee in its GC No. 15 denotes -albeit at a rather abstract level- the need to develop appropriate-measurable indicators towards evaluating States' progress in the implementation of children's right to health without further elaborating on this area.[107]

Unlike the CESCR and the CRC Committee, the first Special Rapporteur on the Right to Health[108] (Paul Hunt), who has also argued in favor of the use of indicators and benchmarks, has attempted to inform and guide States at identifying a set of such tools for measuring their compliance with their treaty obligations. Particularly, Paul Hunt has written three reports and has given considerable and systematic attention to health indicators and benchmarks as tools to enable the realization of the right to health to be monitored and measured.[109]

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105 Ibidem supra note 6, GC No. 14, § 57.

106 Ibid., § 58.

107 Ibidem supra note 13, GC No. 15, § 107.

108 Note by way of background that the Special Rapporteur on the Right to Health is required under the mandate (founding UN Res 2002/31) to prepare reports that offer considerable insights into the normative framework of the right to health and, ultimately, into its effective realization. These reports involve annual reports to the then Commission on Human Rights, the HRC and the GA, as will be discussed more elaborately in section 4.2.3; See, UN Commission on Human Rights, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health -Resolution 2002/31*, 22 April 2002, UN Doc. E/CN.4/RES/2002/31, § 5; See, website of the UN <www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>.

109 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 62nd Sess., Agenda Item 10*, UN Doc. E/CN.4/2006/48, 3 March 2006, §§ 22-61; Paul Hunt has submitted two previous reports to the General Assembly regarding indicators and the right to health. See UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 58th Sess., Agenda Item 117 (c),* UN Doc. A/58/427, 10 October 2003, §§ 5-37 and UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN GA, 59th Sess., Agenda Item 105 (b),* UN Doc. A/59/422, 8 October 2004.

In his 2004 report to the General Assembly Paul Hunt underscored that health indicators may be used to monitor some aspects of the progressive realization of the right to health on condition that:

'a) They correspond, with some precision, to a right to health norm;
b) They are disaggregated by at least sex, race, ethnicity, rural/urban and socio-economic status
c) They are supplemented by additional indicators that monitor four essential features of the right to health:
   (1) A national strategy and plan of action that includes the right to health
   (2) The participation of individuals and groups, especially the vulnerable and disadvantaged, in relation to health policies and programmes
   (3) International assistance and cooperation of donors in relation to the enjoyment of the right to health in developing countries
   (4) Accessible and effective monitoring and accountability mechanisms'.[110]

In his 2003 first interim report to the General Assembly and in his 2006 report, Paul Hunt adopted a set of indicators in relation to health, by pointing out the normative framework that should have in order to be used to measure progress on the realization of the right to health. Accordingly, he defined three categories of indicators, namely *the structural indicators*, *the process indicators* and *the outcome indicators* which were also outlined by the Office of the United Nations High Commissioner for Human Rights in a report of 2008.[111] The *structural indicators* examine the existence of key structures and mechanisms in a country, essential for the realization of the right to health (e.g., national laws - constitutional recognition, policies, institutional mechanisms); the *process indicators* monitor and measure the implementation of health policies (e.g., activities, interventions, programmes); and the *outcome indicators* illustrate the results of health policies/programmes on health status and health-related issues (e.g., maternal mortality, child mortality, HIV prevalence rates).[112]

Contrary to the CESCR and CRC Committee (UN monitoring bodies), the importance of indicators and benchmarks is systematically considered by other

[110] Ibid., UN Doc. A/59/422, § 68.

[111] Ibidem supra note 109, UN Doc. UN Doc A/58/427, §§ 5-37; Ibidem supra note 109, UN Doc. E/CN.4/2006/48, §§ 51-57; See, also, OHCHR, Report on Indicators for Promoting and Monitoring the Implementation of Human Rights, UN Doc. HRI/MC/2008/3, 6 June 2008, <www2.ohchr.org/ English/issues/indicators/docs/HRI.MC.2008.3_en.pdf>

[112] Notably, this classification of indicators was also suggested in his 2004 report, without though being further defined (UN Doc. E/CN.4/2006/48 (supra note 109), §§ 51-57).

human rights bodies in practice, when such tools are interpreted and applied in the assessment of a State's performance. For instance, at the CoE level, the ECSR, being aware of the variance in the level of development of health care among States due to the existing socio-economic conditions, sets out in its 'conclusions' a number of indicators.[113] By doing so, the ECSR acknowledges that the indicators can be a useful tool in evaluating the availability of health care in different States and ultimately in measuring the compliance of States with their obligations under the right to health embedded, *inter alia*, in Article 11 (Revised) ESC (see Part II, section 6.4).[114] The indicators being employed by the ECSR can be summed up, as follows: a) life expectancy, b) rates of mortality, infant and maternal mortality, c) the number of health care facilities (hospitals beds etc.) and health care professionals (doctors, dentists, pharmacists etc.) per inhabitant, d) state health expenditure as a percentage of GDP and e) the existence of waiting lists for hospital treatment. At the same time the indicators, such as life expectancy, rates of mortality and waiting lists can be also applied for measuring accessibility and quality of health care (see Part II, section 6.4). Additionally, the ECSR uses as benchmark the average of all EU countries concerning the above mentioned indicators.[115]

To conclude, the preceding analysis invites three observations. First, the human rights monitoring bodies (e.g., the CESCR and the CRC Committee) generally acknowledge the need for the use of indicators and benchmarks to measure the progressive realization of the right to health and place the responsibility of articulating them on States. The CESCR and the CRC Committee do not systematically use such tools in their concluding observations for States by which to measure implementation of the right to health, which leads to a loss in their practical applicability.[116] Importantly, exceptions in the above observation constitute: a) the 'conclusions' of the ECSR where the Committee identifies and employs a number of indicators as an evaluating tool concerning health care among different

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113 Ibidem supra note 90.

114 For the role of indicators with regard to the compliance of States to treaty obligations see UN Doc. E/CN.4/2006/48 (supra note 109), §§ 22-61; ESC, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) ESC, 3 May 1996, entered into force 1 July 1999, ETS 163.

115 Ibidem supra note 90.

116 See, e.g., UN CESCR, CO: Slovakia, UN Doc. E/C.12/SVK/CO/2, 8 June 2012; UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015; UN CRC Committee, CO: Greece, UN Doc. CRC/C/GRC/CO/2-3, 13 August 2012; UN CRC Committee, CO: Albania, UN Doc. CRC/C/ALB/CO/2-4, 5 October 2012.

countries and b) various reports of Paul Hunt where he defines three categories of indicators and the requirements that must be satisfied in their formulation, the process by which they should be determined.[117] Second, it would be difficult for States to formulate their own indicators and related national benchmarks by which the relevant human rights monitoring bodies can hold them accountable for their treaty obligations. The difficulty of this task is also well founded given research which expressed the concern as to 'how to determine what would be a realistic and reasonable pace of progress in light of available resources'.[118] Third, in academic literature, Toebes, for instance, expressed the concern that even if States formulate and use such tools, 'the danger exists that they cease to progressively improve their socio-economic situation as soon as the required level has been attained'.[119] Thus, caution must be exercised with respect to the utility of indicators and benchmarks given the above concerns. In fact, this could allow human rights monitoring bodies to more reliably monitor a State's progress as to the effective and progressive realization of the right to health within a State's jurisdiction and to identify (potential) State violations.[120] Nonetheless, if carefully applied (i.e. sensitive to national realities and particularities), the significance attached to the use of such tools should not be overlooked. Some academic commentators have argued on their significance by stressing that 'it seems possible to attune the core content of a social right to a country's level of development'.[121]

3.7. CHALLENGES ON THE WAY AHEAD: AN OVERVIEW

Ensuring the right to health for all individuals gives rise to a number of significant and practical issues, involving, *inter alia*, the privatization and corruption. Increasingly, human rights bodies are addressing either explicitly or implicitly these two issues as challenging the objectives of the right to health (see below sections 3.7.1.-3.7.2. and Part II, section 6.5). Nevertheless, this section will elucidate privatization and corruption in relation to one dimension of the right to

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117 Note that the Special Rapporteur on the Right to Health (Paul Hunt) in his country reports utilizes indicators, such as the number of hospital beds, to measure national implementation of the right to health (care) (e.g., see, Mission to Sweden, UN Doc. A/HRC/4/28/Add.2, § 43).

118 Ibidem supra note 63, J. Tobin 2012, p. 213. (citing relevant studies)

119 Ibidem supra note 5, B. Toebes 2001, p. 185.

120 Ibid., see for an analogous approach as to the application of benchmarks.

121 A. Hendriks, 'The Right to Health. Promotion and Protection of Women's Right to Sexual and Reproductive Health under International Law: The Economic Covenant and the Women's Convention', *The American University Law Review* 1995, 44, pp. 1123-1144, p. 1138.

health, namely health care.[122] Importantly, the subsequent analysis can also have application to the underlying determinants of health.[123]

But firstly, we need to elucidate what a 'health system' encompasses as its development is at the forefront of our analysis in relation to the concerns raised within human rights law domain about privatization and corruption in the health sector. As such, two basic (expansive) definitions of how a health system can be conceptualized are most commonly used in literature. Accordingly, a health system can be understood to encompass: (i) all organizations, people and actions whose primary purpose is to promote, restore or maintain health involving efforts to 'influence *the determinants of health* as well as more direct-health improving activities'[124] [emphasis added] and (ii) the people, institutions and resources, arranged together in consistency with established policies, to enhance the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to enhance health.[125] Interestingly, such definitions of a health system suggest an integrated health system that will reflect the broad and inclusive conception of the content of the right to health (i.e., access not only to healthcare, but also to the underlying determinants of health) (see section 3.2).[126]

In line with the aforementioned definitions, a study by Mackintosh and Koivusalo[127] pointedly suggests that health systems should be defined by

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122 Ibidem supra note 6, GC No. 14, § 11.

123 For instance, the concepts of privatization and corruption can be applied in a case of water and/or education services; See, e.g., with respect to education services: S. Gupta, H.R. Davoodi & E.R. Tiongson, *Corruption and the Provision of Health Care and Education Services*, IMF Working Paper (WP/00/116), Fiscal Affairs Department – IMF, Washington, D.C. 2000, pp. 25-26.

124 WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes,* Geneva: World Health Organization 2007, p. 2.

125 WHO, *Health Systems Strengthening: Glossary*, Geneva: World Health Organization 2011, p. 9; WHO, *World Health Report 2000. Health Systems: Improving Performance*, Geneva: World Health Organization 2000.

126 Ibidem supra note 6, GC No. 14, § 9; See for a similar statement, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 7th Sess., Agenda Item 3,* UN Doc. A/HRC/7/11, 31 January 2008, § 15; B. Toebes, *Human rights, health sector abuse and corruption*, Human Rights and Human Welfare Working Paper No. 64, 1 April 2011, p. 6.

127 M. Mackintosh & M. Koivusalo, 'Health Systems and Commercialization: In Search of Good Sense' in: M. Mackintosh & M. Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses,* Hampshire: Palgrave 2005, pp. 3-21, p. 6.

their objectives-stated goals (i.e., *'what health systems do'*), which should encompass:

(a) Protection and promotion of the health of the general population and provision of preventive and emergency services ('public health').
(b) Provision of health services and care for all people pursuant to their need and financing of these based on their ability to pay ('health services'). Health services can be defined as activities that are intended to restore and maintain the health of an individual through prevention, diagnosis or treatment of disease, rehabilitation and long-term care.[128]
(c) Securing training, surveillance and research for the maintenance and enhancement of the health of the general population and health services and availability of a skilled medical workforce ('human resources and knowledge').
(d) Securing ethical integrity and professionalism, planning and accountability, patients' rights, including participation and involvement of users and respect of confidentiality and dignity in the provision of services ('ethics and accountability').[129]

3.7.1. PRIVATIZATION

In general, privatization involves the sale or (total or partial) transfer of state-owned assets into private hands as well as the transfer to private hands of an activity previously carried on by a public authority, whether or not accompanied by a transfer of property.[130] Privatization as such linked to health insurance and/or health care provision has the potential to directly impact upon the realization of national health-related objectives.[131] Indeed, it can contribute to the advancement

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[128] WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes,* Geneva: World Health Organization 2007; See, also, K. Facey, *Health Technology Assessment (HTA) Glossary*, International Network of Agencies for Health Technology Assessment, 1st edition. Stockholm: INAHTA Secretariat 2006.

[129] Ibidem supra note 127, M. Mackintosh & M. Koivusalo, p. 6.

[130] Council of Europe, 'Privatization of public undertakings and activities: Recommendation No. R (93) 7 adopted by the Committee of Ministers of the Council of Europe on 18 October 1993 and explanatory memorandum', Strasbourg: Council of Europe Press 1994, p. 5; Ibidem supra note 127, M. Mackintosh & M. Koivusalo 2005, p. 4. Of note, instead of the concept of privatization, Mackintosh and Koivusalo employ the term 'commercialization', which is broader than the private sector of provision and finance, involving, *inter alia*, commercial behaviour by publicly owned bodies (i.e. the contracting out of health services to private healthcare providers).

[131] See, e.g., E.A. Friedman, 'Building Rights-Based Health Systems: A Focus on the Health Workforce' in: A. Clapham & M. Robinson (eds), *Realizing the Right to Health,* Zurich: Rüffer & Rub 2009, pp. 421-435, p. 428; Ibidem supra note 64, B. Toebes 2006, p. 111.

of the health status of the general population, for instance, by means of introducing new health technologies and enhancing timely access to quality health services through the creation of competition.[132] At the same time, while there is a growing global trend in the privatization of health sector, from a human rights perspective there is a concern as to the (potential) negative consequences of such process on general population's health.[133] In fact, in health and human rights literature, it is recognized that privatization 'can have a negative effect on health outcomes and on the accessibility of health care services for poor and disadvantaged people, in particular in poorer countries'.[134] Importantly, over the years such concerns have been also expressed by UN human rights bodies, for instance by both the CESCR and the CRC Committee in their concluding observations.[135] Similarly, the second Special Rapporteur on the Right to Health (Anand Grover) in his report on health financing has underpinned that 'privatization in health systems poses significant risks to the equitable availability and accessibility of health facilities, goods and services, especially for the poor and other vulnerable or marginalized groups'.[136] Nonetheless, the CESCR in its GC No. 3 has explicitly remarked the neutrality of ICESCR with regard to the economic system implemented by a State in order to comply with its obligations that flow from the Covenant, *inter alia,* the full implementation of the right to health.[137] This approach gives discretionary power

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132 See, e.g., S. Gruskin & D. Tarantola 'Health and Human Rights' in: S. Gruskin, M.A. Grodin, G.J. Annas & S.P. Marks (ed.), *Perspectives on Health and Human Rights*, New York and London: Routledge 2005, pp. 3-57, pp. 28-29; Ibid.

133 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover. UN GA, 67th Sess., Agenda Item 70(b),* UN Doc A/67/302, 13 August 2012, § 3; Ibid., S. Gruskin & D. Tarantola 2005, pp. 3-57, p. 29.

134 Ibidem supra note 64, B. Toebes 2006, p. 106 (citing other similar studies).

135 See, e.g., UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 38; UN CESCR, CO: Poland, UN Doc. E/C.12/POL/CO/5, 2 December 2009, § 28; See e.g., UN CRC Committee, CO: Czech Republic, UN Doc. CRC/C/15/Add.201, 18 March 2003, § 52.

136 Ibidem supra note 133, UN Doc. A/67/302, § 3.

137 Ibidem supra note 43, GC No. 3, § 8. Specifically, it reads as follows: 'The Committee notes that the undertaking "to take steps ... by all appropriate means including particularly the adoption of legislative measures" *neither requires nor precludes any particular form of government or economic system* being used as the vehicle for the steps in question, provided only that it is democratic and that all human rights are thereby respected. Thus, in terms of political and economic systems *the Covenant is neutral* and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or laissez-faire economy,

to the State with regard to its interpretation in practice. As such, each State has a freedom to choose whatever system (i.e. private or public mix) it considers to be most suited to its national context.[138]

In light of the preceding, it should be, though, observed that privatization of the health sector must not be regarded as an excuse by the States for not complying with their treaty obligations under the right to health.[139] Most illuminating in this respect is the authoritative approach adopted by the CESCR (in its GC No. 14.) that States must '… ensure that the privatization of the health sector does not constitute a threat …' to the four elements of the right to health (i.e., the AAAQ - see section 3.5) in terms of their obligation *to protect* the right to health (see section 3.3).[140] Meanwhile, this approach was subsequently underpinned by the CRC Committee during the day of general discussion on the theme 'the private sector as service provider and its role in implementing child rights' in 2002 and later (2013) reiterated in its GC No. 15.[141] In fact, the CRC Committee observed that 'in any decentralization or privatization process, the Government retains clear responsibility and capacity for ensuring respect of its obligations under the Convention.'[142] Thereby, States bear a clear primary responsibility for ensuring that private health care actors act in conformity with human rights law in the context of guaranteeing a right to health to everyone.

In addition to the State, the potential responsibility of non-State actors (non-governmental organizations, civil society groups, private business sector etc.) towards human rights has been generally considered in various other human rights documents. Nevertheless, it is important to stress that these documents do not

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or upon any other particular approach…' [emphasis added]; Ibidem supra note 6, GC No. 14, § 12(b). Under the notion of economic accessibility ('…ensuring that these services, *whether privately or publicly provided*, are affordable for all…') [emphasis added], the Committee indirectly stresses its neutral position concerning the system of delivery of health services (private or public health system).

138 See also for a similar statement regarding the organization of a national health system supra note 1, B.C.A. Toebes 1999, p. 248.

139 See, e.g., Recommendation 1626 (2003) of the Parliamentary Assembly of the Council of Europe on "the reform of health care systems in Europe: reconciling equity, quality and efficiency", 1 October 2003; Ibidem supra note 6, GC No. 14, § 35; Ibidem supra note 1, B.C.A Toebes 1999, p. 141.

140 Ibidem supra note 6, GC No. 14, § 35.

141 UN CRC Committee, *Report on the Thirty-First Session*, UN Doc CRC/C/121, 11 December 2002, Ch VI, pp. 149 and 153-154, §§ 640 and 653(4) and (8); Ibidem supra note 13, GC No. 15, §§ 76 and 79.

142 Ibid., UN Doc CRC/C/121, Ch VI, p. 155, § 653(15).

provide a legal basis upon which non-State actors are directly bound by human rights obligations. For instance, the UN Sub-Commission on the Promotion and Protection of Human Rights has adopted 'norms on the responsibilities of transnational corporations and other business enterprises with regard to human rights'. This non-binding document provides that even though States bear the primary responsibility towards human rights, 'within their respective spheres of activity and influence, transnational corporations and other business enterprises have the obligation to promote, secure the fulfillment of, respect, ensure respect of and protect human rights recognized in international as well as national law'.[143] Similarly, the UDHR generally recognizes in its preamble the human rights responsibilities of 'every individual and every organ of society'.[144]

The aforementioned approach is supplemented by other human rights documents with respect to the realization of the right to health. For instance, the CESCR in its non-legally binding GC No. 14 observed that 'While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, ..., as well as the private business sector - have responsibilities regarding the realization of the right to health (…).'.[145] In addition to the CESCR, Hunt in his report to the UN Human Rights Council has underpinned the significance of an effective interaction among public and private actors in health care delivery under the auspices of a State's regulated health system.[146] Interestingly, the importance of cooperation between the State and public or private organizations towards the realization of the right to health has been addressed within the context of the CoE and in a binding manner under Article 11 (Revised) ESC.[147]

On the basis of the preceding analysis it is observed that health sector privatization is, in principle, not contrary to the effective enjoyment of the right

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143 UN Sub-Commission on the Promotion and Protection of Human Rights, *Norms on the Responsibilities of Transnational Corporations and other Business Enterprises with regard to Human Rights,* U.N. Doc. E/CN.4/Sub.2/2003/12/Rev.2 (2003), approved 13 August 2003, by UN Sub-Commission Res. 2003/16, U.N. Doc. E/CN.4/Sub.2/2003/L.11 at 52 (2003), § 1.

144 Preamble of the Universal Declaration of Human Rights (UDHR) 10 December 1948, GA res. 217(III), UN Doc. A/810 at 71(1948).

145 Ibidem supra note 6, GC No. 14, § 42.

146 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 7th Sess., Agenda Item 3,* UN Doc. A/HRC/7/11, 31 January 2008, §§ 47, 57, 102 and 119.

147 ESC, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) ESC, 3 May 1996, entered into force 1 July 1999, ETS 163.

to health by every individual within a State's jurisdiction. It is the privatization which is poorly conceived, regulated and monitored by the State that poses a threat to the objectives of the right to health and, finally, to its enjoyment by every individual (see Part II, sections 5.2.2 and 6.5.1). For that purpose, in human rights literature, a useful typology of state obligations, arising from 'the obligation to protect', is identified which entails the following obligations:

(a) The adoption of legislation to regulate the (private) actors in the health sector;
(b) The adoption of monitoring mechanisms aimed at regulating the behaviour of private health care providers, insurance companies and pharmaceutical companies;
(c) The establishment of judicial and/or other remedies for individuals concerning failure or malpractice by (private) actors in the health sector (legal accountability mechanisms).[148]

Thereto, the State, as primary duty holder, is obliged to create an environment in which all actors, including the private sector, can contribute to the realization of the right to health through the discharge of the responsibilities imposed by the State and through the development of effective participatory mechanisms (see section 3.5) in health-related planning and health care law and policy-making.

3.7.2. CORRUPTION

In addition to privatization, another serious issue that has received heightened attention within the human rights law domain is corruption. Corruption is generally understood to refer to 'the abuse of power for private gain', which is a widely used definition.[149] In recognition of the impact of corruption in society, in 2003, the UN General Assembly adopted the UN Convention against Corruption

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[148] B. Toebes, 'Taking a human rights approach to health care commercialization', in: P.A. Cholewka & M.M. Motlag (eds) *Health Capital and Sustainable Socioeconomic Development*, London and New York: CRC Press - Taylor and Francis 2008, pp. 441-458, p. 451; As regards to the obligation to protect, see GC No. 14 (supra note 6), §§ 35, 51 and 59 (emphasis on legal accountability); Of note this typology of State obligations can be also applied to prevent health sector corruption (see below section 3.7.2).

[149] See, e.g., European Commission, *Study on Corruption in the Healthcare Sector*, Luxembourg: Publications Office of the European Union 2013, p. 17; Transparency International *Global Corruption Report 2006,* London: Pluto Press 2006, p. xvii (Corruption is defined as 'the abuse of entrusted power for private gain').

(UNCAC).[150] The Convention initially sets out a number of measures that States are required to take, aiming at the prevention of corruption.[151] Corruption is defined in the UNCAC through the identification of specific criminal acts, such as the *bribery* of national and foreign public officials and officials of public international organizations and bribery in the private sector, *embezzlement* of property by a public official, *trading in influence*, *abuse of functions* and *illicit enrichment*.[152] Additionally, the UNCAC urges States to cooperate with private actors in an effort to promote active participation of society and raise public awareness 'regarding the existence, causes and gravity of and the threat posed by corruption'.[153] In a similar vein, some institutions have paid attention to the significance of participation in the fight against corruption. An elucidating study by IMF on corruption in healthcare reveals that 'participation of the poor in the decisions that influence the allocation of public resources would mitigate corruption possibilities'.[154]

Importantly, with respect to the legal anti-corruption framework, in addition to the UNCAC, at the CoE level, the Criminal Law Convention on Corruption (CoE Criminal Law Convention) and the Civil Law Convention on Corruption (CoE Civil Law Convention) address the issue of corruption by identifying corrupt acts and requiring the Signatory States to develop and implement effective legislative and other measures to tackle corruption as well as by urging them to promote international co-operation in cases of corruption.[155] In particular, the CoE Criminal Law Convention covers a wide range of offences, involving, *inter alia*, the active and passive *bribery* of domestic public officials, bribery of foreign public officials, active and passive bribery in the private sector and *trading in influence*.[156]

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150 The United Nations Convention against Corruption, adopted in New York, 31 December 2003, entered into force 14 December 2005, UN Doc. A/58/422. As at 30 June 2016 178 States, including Greece, were parties to the Convention.

151 Articles 5-14 UNCAC (in Chapter II: 'Preventive Measures').

152 Articles 15-21 UNCAC (in Chapter III: 'Criminalization and Law Enforcement'). A distinction is made between active (offering and giving a bribe) and passive (accepting a bribe) bribery.

153 Articles 12-13 UNCAC (in Chapter II: 'Preventive Measures').

154 Ibidem supra note 123, S. Gupta, H.R. Davoodi & E.R. Tiongson, pp. 25-26.

155 CoE, Criminal Law Convention on Corruption, adopted on 27 January 1999, entered into force on 1 July 2002, ETS No. 173. As at 30 June 2016, total number of ratifications: 45, including Greece and one non-member of the CoE; CoE, Civil Law Convention on Corruption, adopted on 4 November 1999, entered into force on 1 November 2003, CETS No. 174. As at 30 June 2016 total number of ratifications: 35, including Greece and one non-member of the CoE, available at http://conventions. coe.int.

156 Articles 2-12 (in Chapter II: 'Measures to be taken at national level') CoE Criminal Law Convention.

On the other hand, the CoE Civil Law Convention requires the Signatory States to provide effective remedies for individuals who have suffered damage owed to acts of corruption.[157] These two CoE Conventions together with the UNCAC, which only embraces criminal acts, can guide States to establish a robust framework for combating corruption at the national level.

Meanwhile, concerns about corruption in relation to the enjoyment of the right to health have been expressed either explicitly or implicitly in UN human rights documents. The CESCR, for instance, in its GC No. 14 has indirectly addressed corruption in relation to the right to health by expressing its concern that 'inappropriate health resource allocation can lead to discrimination that may not be overt'.[158] On the other hand, in his report to the then Commission on Human Rights, Hunt has explicitly remarked that corruption prevents the enjoyment of the right to health especially with respect to vulnerable population groups.[159] Additionally, the CRC Committee has referred to 'the paralyzing effect' of corruption on government and public services, including in the area of health.[160] Such concerns are also well founded on given literature which suggests that corruption in healthcare may lead to inappropriate health resource allocation and, thereby, may threaten the realization of the right to health indirectly in the field of healthcare.[161] Additionally, corruption may directly affect vulnerable groups, such as poor people, as it deprives people of access to health care due to their inability to afford excessive informal payments.[162] Such approaches raise concerns in light of the 'accessibility', 'acceptability' and 'quality' requirements under the right to health framework (section 3.5).[163] As such, this matter signals dangers for the goal of universal health coverage and, ultimately, for increased inequality in health status among diverse socioeconomic population groups.

Last but not least, the vulnerability of the health sector to corruption, which

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157 Article 5 (in Chapter I: 'Measures to be taken at national level') CoE Civil Law Convention.

158 Ibidem supra note 6, GC No.14, § 19.

159 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc E/CN.4/2003/58, 13 February 2003, § 98.

160 Ibidem supra note 141, UN CRC Committee, pp. 151-152, §§ 648 and 651.

161 B. Toebes, 'Human rights and health sector corruption' in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 102-134.

162 Ibid.

163 Such concerns are also addressed in Part II, section 6.5.2 concerning a country case study.

primarily impacts upon the right to health as aforementioned, has been identified by elucidating reports of respective institutions and organizations. For instance, in 2013, the European Commission issued a report on corruption in the health sector regarding all the 28 EU Member States.[164] This report stresses that corruption in the health sector occurs in all EU Member States and that the health sector is one of the areas particularly vulnerable to corruption.[165] In this regard, a comprehensive analysis of health sector corruption set out by Transparency International (TI), a global civil society organization, elucidates that this vulnerability is associated with three main factors: an imbalance of information in health systems (not equally available to all health sector actors), the uncertainty in health markets and the complexity of health systems which impede accountability (see section 3.5). [166] Of note, the complexity of health systems can be in part attributed to the several actors, State and non-State actors, involved within a health care context and their interaction.[167] Additionally, Savedoff and Hussmann in Transparency International's 2006 'Global Corruption Report', particularly in their analysis of the causes of corruption in health systems, identify the following five key categories of actors whose interests might encourage health sector corruption:

(a) Regulators (governments, health ministries, parliaments, supervisory commissions);
(b) Payers (social security institutions, public and private insurers);
(c) Health Care Providers (hospitals, health professionals: doctors, nurses, pharmacists);
(d) Consumers (patients);
(e) Suppliers (pharmaceutical companies, producers of medical equipment).[168]

In their attempt to explain why health systems are prone to corruption, Savedoff and Hussmann have also affirmed that 'corruption in the health sector is not exclusive to any particular kind of health system. It occurs in systems whether they

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164 Ibidem supra note 149, European Commission.

165 Ibid.

166 Transparency International (TI), *Global Corruption Report 2006, Special Focus - Corruption and Health,,* London: Pluto Press 2006, p. xvii; See also, K. Hussmann, *Addressing corruption in the health sector-Securing equitable access to health care for everyone*, Norway: Christian Michelsen Institute (CMI) -U4 (anti-corruption resource center) issue January 2011 No1, pp. 5-6.

167 Ibid.

168 W.D. Savedoff & K. Hussmann, 'Why are health systems prone to corruption?', in Transparency International, *Global Corruption Report 2006, Special Focus - Corruption and Health,* London: Pluto Press, pp. 4-13, pp. 8-10.

are predominantly public or private, well-funded or poorly funded, and technically simple or sophisticated. The extent of corruption is in part a reflection of the society in which it operates. Health system corruption is less likely in societies where there is broad adherence to the rule of law, transparency and trust, and where the public sector is ruled by effective civil service codes and strong accountability mechanisms'.[169] To conclude, in the fight against health sector corruption, States, as primary duty holders, should, *inter alia*, introduce supervisory mechanisms, including taking administrative, financial or broader institutional measures, in order to prevent and control corruption (as regards to a delineation of a set of State obligations, see section 3.7.1.). Nevertheless, in addition to the State's primary and overall responsibility, private actors (e.g., insurers, suppliers) should not encourage corruption, as they (potentially) also have correlative responsibility concerning the realization of the right to health, as mentioned before in section 3.7.1.[170]

3.8. CONCLUSIONS

The thrust of this chapter was to provide an understanding on the various aspects of the content of the right to health which could regulate its realization at the national level, whist keeping in mind that within literature there are critical views of the right to health and its particular aspects. In this regard, this chapter examined the nature and scope of the right to '*the highest attainable standard of health'* ('right to health'), the state obligations arising from it as well as two concepts which signal dangers for its realization. As such, the analysis in the preceding sections invites the following six observations that make the right to health and the state obligations arising from it more tangible, in that they have the potential to provide operational standards for States (when used in due caution) that are to be translated into law.

First, the achievement of the highest attainable standard of health must be based on the fact that the right to health is a broad right covering both a right to health care and a right to the underlying conditions for health, such as access to safe drinking water, to health-related information, occupational health and the protection of environmental health. Nevertheless, the broad scope of the right to health demonstrates a normative overlap with other human rights. Given this overlap, caution is required not to consider everything that influences the health status of individuals as part of this scope. As such, the right to health should be conceived as a right distinct from the others based on issues explicitly addressed

[169] Ibid., p. 4.

[170] Ibidem supra note 6, GC No. 14, § 42; Ibidem supra note 144, Preamble of the UDHR.

in right to health provisions, such as Article 12 ICESCR, 24 CRC. This conceptualization could strengthen its practical applicability.

Second, while several objections against its applicability have been expressed, the tripartite typology of obligations *to respect, to protect, to fulfil* which impose a range of positive and negative duties on States could be regarded as a useful means in helping to clarify the content of the right to health and the type of measures required for its effective implementation. Generally, this typology in relation to the right to health demonstrates that this right requires of States both acting towards the adoption of measures to ensure its effective realization and the regulation of the impact of non-state actors on individuals' health as well as abstaining from interfering with the enjoyment of the right to health. Subsequently, States must give recognition to the right to health within their national health policies and national legal systems. Additionally, based on the tri-partite typology of State obligations concrete violations of the right to health can be defined as well as correlative responsibilities of non-State actors and issues of resource allocation can be raised.

Third, the application of the tripartite typology alone is not sufficient for States to identify the nature of state obligations arising from the right to health due to the progressive nature of this right. Therefore, this typology needs to be complemented by the progressive nature of the right and its core content. Noting that the right to health is to be progressively realized, namely gradually over a period of time, States enjoy a certain level of policy freedom. Nonetheless, the State's policy freedom is limited by a number of clauses, such as the clause of the maximum of a State's available resources; abstaining from taking deliberately retrogressive measures; the clause of non-discrimination which is of immediate effect; and the core content of the right to health whose implementation is non-derogable. In fact, in case of retrogressive measures due to resource scarcity all possible alternatives must be considered, in order to reduce the impact of such measures and achieve the right to health. Furthermore, while its definition and application remains surrounded with a lot of controversy, the core content of the right to health which is framed in terms of immediate state obligations could play a role in identifying -albeit with due caution- a set of basic concrete state undertakings under all circumstances, irrespective of a State's level of development and resources.

Fourth, when it comes to transforming the broad concept of the right to health into tangible elements that can be operationalised by States, considerable attention should be paid also to the so-called 'AAAQ'. The 'AAAQ' is a significant tool for the analysis of state obligations with respect to health care. Particularly, as laid down in the two existing GCs on the right to health, health care facilities, goods and services must be available, accessible, acceptable and of good quality. The

'AAAQ' can be a practical and flexible tool for guiding the design and implementation of operational policies responsive to the health needs of individuals and groups at the national level. They are universally applicable, and as such they can be used as a yardstick for assessing the effects of national health care reforms and allow for comparison between countries for revealing best practices. Of note, the 'AAAQ' are broad and their precise application is a matter falling within the discretion of each State, namely it is dependent on the conditions prevailing in a particular State, for instance on resource availability. Nevertheless, their application is subject to the overall requirement that whatever measure is adopted, it must contribute to the effective realization of the right to health. In addition to the AAAQ, the importance of other notions has been discerned which expand this four-fold classification of guidelines, namely the notion of accountability and participation ('AP'). The application of these two additional notions can offer a comprehensive supplementary framework that will ensure the delivery of better policy outcomes within the context of realizing the right to health at the national level.

In addition to the 'AAAQ' and 'AP', indicators and national benchmarks are also considered as a way of framing more concretely the right to health and, consequently, of measuring a State's progress (or the lack of it) with regard to its effective realization. It was, though, discerned that various obstacles surround their utility, which are largely connected to the progressive nature of the right to health. Nonetheless, the development of reliable indicators (i.e. sensitive to national realities) and national benchmarks, against which laws and/or practice can be measured, can assist in the formulation and implementation of national policies that give effect to the right to health.

Finally, we have briefly examined two challenges, namely privatization and corruption within the context of the right to health and, particularly in the field of health care. These two challenges raise some points of concern when it comes to ensuring the effective realization of the right to health of every individual. Nevertheless, as discussed in the respective section, privatization linked to health insurance and/or health care provision does not absolve States from their primary and overall obligations for realizing the right to health. On the contrary, States are required to adopt legislation and sufficient monitoring and accountability mechanisms aimed at regulating the behavior of all (non-State) actors involved in the health sector. Likewise, another issue that was identified and has received heightened attention within the human rights law domain is corruption. Corruption in the health sector constitutes a serious issue hindering the realization of the right to health for every individual, particularly in light of the 'accessibility', 'acceptability' and 'quality' requirements as set out in the right to health framework.

As such, it is incumbent upon States to adopt legislation and accountability mechanisms to supervise all actors whose interests might encourage corruption in the health sector.

All in all, it becomes clear that beyond the formulation of the right to *'the highest attainable standard of health'* in international law, over the years the understanding of health as a right has evolved to encompass various components as well as State obligations. As such, the understanding of what the right to health entails contributes to turn the broad and abstract notion of *the highest attainable standard* into concrete concepts that can be utilized for its effective realization worldwide and particularly when it comes to implementing this right at the national level. It is this aspect of the right to health that constitutes the basis of the analysis in chapter 4 and will be further explored as a country case study in Part II.

4 The Realization of the Right to Health: The Role of the State*

4.1. INTRODUCTION

As discussed in Chapter 2, the right to health finds recognition within an array of international and regional human rights treaties as well as in many national constitutions around the world. This has not, however, resulted in the full enjoyment of the right to health by everyone and in the appraisal of health as a legally binding right worldwide. Statistics from WHO, for example, indicate that still about 18,000 children and 800 women worldwide died every day in 2012 and in 2013 respectively, due to medical conditions that were at a large extent preventable or curable with simple medical interventions.[1] Additionally, about 8.6 million of the global population developed tuberculosis and 13 million died from that disease in 2012.[2] Thus, these and other avoidable health problems demonstrate that the realization of the right to health is a key component of the protection of health and without it health protection is just an empty promise.

Given the gravity of such concerns over time, the UN High Commissioner for Human Rights in a report of 2009 has cautioned that the realization of ESC rights, such as the right to health, demands 'action to translate the specific commitments included in legislation and other normative instruments into reality'.[3] This implies that States -primary duty holders under international law- are required to take concrete measures towards addressing the obstacles to an individual's

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* The word 'State' involves all components and all levels of public authorities.

1 See, World Health Organization, *World Health Statistics 2014*, Geneva: WHO, pp. 13 and 15.

2 Ibid., p. 16; Notably, every year almost 7 million children die under the age of five, mostly from preventable diseases. <https://m.savethechildren.net/what-we-do/health-and-nutrition>

3 UN Economic and Social Council, *Report of the High Commissioner for Human Rights on Implementation of Economic, Social and Cultural rights,* UN Doc. E/2009/90, 8 June 2009, § 34.

effective enjoyment of the right to health (e.g., lack of primary health care, embedded health inequalities, resource constraints etc.).[4] For instance, Upendra Baxi, legal scholar pointedly argues that 'one may not take rights seriously if one is unable to take [human] suffering seriously'.[5]

In this chapter the focus of attention shifts to explore the enforcement of the right to health on the part of the State, in virtue of its primary and overall responsibility for realizing the right to health for all persons within its jurisdiction.[6] Therefore, an analysis of the nature of state measures required in realizing the right to health in section 4.2, as elaborated by the work of three UN human rights monitoring bodies may provide an additional insight into the realization process of the right to health at the national level. After providing an account of the nature of state measures, in section 4.3, the justiciability of the right to health with a focus on Europe, namely on the work of European Committee of Social Rights, will be explored. In section 4.4 the obligation imposed on States to internationally co-operate as a way of ensuring the realization of the right to health will be also discussed.

4.2. UN HUMAN RIGHTS MONITORING BODIES

In general, monitoring involves a systematic collection of information towards assessing States' compliance with their human rights commitments.[7] It can offer some feedback for implementation, in that the assessment of the process followed and the outcomes accomplished comprises information that can be used 'to either confirm the direction of some specific steps, or to correct them when necessary'.[8] As such, monitoring and implementation can be seen as two intertwined procedures.[9] The UN treaties provide for two primary mechanisms to monitor a State's compliance with its human rights obligations: the State reporting procedure and the individual complaints procedure.[10] In light of the aforementioned, the growing recognition of the right to health in human rights law is not enough from

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4 See, e.g., Article 2 § 1 CRC: 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction…'; Ch. R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, p. 114.

5 U. Baxi, 'Taking Suffering Seriously: Social Action Litigation in the Supreme Court of India', *Third World Legal Studies* 1985, Volume 4, Article 6, pp. 107-132, p. 120.

6 Ibidem supra note 4.

7 Ibidem supra note 3, UN Doc. E/2009/90, § 5.

8 Ibid., § 8.

9 Ibid.

10 See UN website of the Office of the UN High Commissioner for Human Rights: 'Monitoring the core international human rights treaties' <www.ohchr.org/EN/HRBodies/Pages/WhatTBDo.aspx>.

its own. The work of monitoring bodies on the progress of States parties as to the implementation and compliance with their right to health obligations can perhaps constitute a potential useful procedure in that it could offer an account of the state measures required for ensuring the effective enjoyment of this right for all persons within a State's jurisdiction (see below sections 4.2.1 and 4.2.2). Generally speaking, their task involves an assessment process, *inter alia*, for the identification of (potential) inadequacies in laws/policies/practices at the national level and marks the first step for their review and alteration by the respective States (see below sections 4.2.1 and 4.2.2). Nonetheless, this is not to say that the work of monitoring bodies is beyond criticism, as several scholars have been critical of various aspects of their work (e.g. capacity, legal authority etc.).[11]

At the international level, the implementation of the right to health by the State parties is primarily monitored by UN treaty monitoring bodies related to the respective international human rights treaties that enshrine a right to health. Each of these human rights treaties has its own committee to monitor its implementation, establish interpretations, set standards and investigate infringements of the right to health.[12] In the following sections, consideration shall be given to the work of the CESCR and the CRC Committee, as these bodies monitor the compliance of States with their treaty obligations, *inter alia*, under the right to health embedded in ICESCR and CRC, respectively.[13] Additionally, both bodies have adopted General Comments (henceforth: GCs) on *the right to the enjoyment of the highest attainable standard of health* (the right to health), in order to complement the specifications about this right enshrined in respective human rights treaties, as elaborated in section 2.2.4.[14] Particularly, the respective Committees -albeit their

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[11] See, e.g., M. Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Antwerp: Intersentia, 2003, p. 316; E. Riedel, 'The Human Right to Health: Conceptual Foundations', in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 27.

[12] Ibidem supra note 10.

[13] See sections 4.2.1 and 4.2.2.; Note that the majority of the world's States have ratified ICESCR and CRC. Particularly, as at 30 June 2016, 164 States were parties to the ICESCR and 196 States were parties to the CRC.

[14] The CESCR has adopted General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000 as well as other GCs relating to a right to health, *inter alia*, GC No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016. The CRC Committee has adopted General Comment No. 15 *on the right of the child to the enjoyment of the highest attainable standard of health,* UN Doc. CRC/C/GC/15, 14 March 2013 as well as several other GCs relating to a right to

work is sometimes quite ambiguous (see chapter 3)- have still made attempts to analyze the right to health and to guide States parties as to the content of this right and the nature of the ensuing state obligations.[15] In addition to the above treaty-based mechanism, attention shall be drawn to the work of the UN Special Rapporteur on the Right to Health[16], who is required under his/her mandate to prepare reports that offer insights into the normative framework of the right to health and, ultimately, into its effective realization.[17]

As such, the following sections will take into account the work of three UN monitoring bodies, principally the CESCR, the CRC Committee and the Special Rapporteur on the Right to Health, in an attempt to inform the scope of the meaning of the broad state obligation to realize the right to health by taking 'all appropriate means' or 'all appropriate measures' subject to a State's available resources, which is imposed by both the ICESCR (Articles 2 § 1 and 12) and the CRC (Articles 4 and 24). Note also that based also on the preceding analysis in section 3.4 on the progressive and immediate nature of state obligations resulting from the right to health, these two additional clauses could regulate the realization of this right and, thus, could function as a yardstick to evaluate the degree of realization of the right to health on the part of the State. Additionally, within the framework of the State reporting procedure several Concluding Observations (henceforth: CO) of the respective Committees -issued mainly since 2000- are taken into account by way of illustration, as these could perhaps offer States some

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health, *inter alia*, GC No. 3: *HIV/AIDS and the Rights of the Child*, UN Doc. CRC/GC/2003/3, 17 March 2003, GC No. 4*: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, 1 July 2003.

15 See generally, UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 62nd Sess., Agenda Item 72(b),* UN Doc. A/62/214, 8 August 2007, § 70.

16 See, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res 2002/31, UN Doc. E/CN.4/RES/2002/31, 22 April 2002, which established the mandate of the Special Rapporteur on the Right to Health; See, also, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res 2005/24, UN Doc. E/CN.4/RES/2005/24, 15 April 2005 and UN Human Rights Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res 6/29, UN Doc. HRC/RES/2007/6/29, 14 December 2007, which both renewed the respective mandate for further three years.

17 These reports involve annual reports to the then Commission on Human Rights, the Human Rights Council and the UN GA, as will be discussed more elaborately in section 4.2.3; See website of the UN <www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>.

guidance as to the scope of and compliance with the respective broad state obligation under the right to health.[18]

4.2.1. UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The CESCR is the body of 18 independent experts mandated to monitor the implementation by the State parties of the right to health (Article 12 ICESCR), among other rights embedded in ICESCR.[19] In particular, a State reporting system under the aegis of the ECOSOC was established according to Articles 16-23 ICESCR. State parties to the ICESCR are obligated to submit periodic reports on 'the measures which they have adopted and the progress made in achieving the observance of the rights recognized' in the ICESCR in accordance with the Committee's 'reporting guidelines'.[20] As mentioned earlier, the ICESCR did not provide for the establishment of a treaty monitoring body, to monitor its implementation. Such a body, the CESCR was later established, in 28 May 1985 under Res 1985/17 of the ECOSOC to fulfil the monitoring functions assigned to the ECOSOC in Part IV of the Covenant.[21] Note also by way of background that since 2013, when an Optional Protocol to the ICESCR entered into force, the protection given to ESC rights is to the same extent to that of CP rights at the UN level.[22]

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[18] As already mentioned, in 2000 in its GC No. 14 the CESCR provided an authoritative interpretation of the right to health enshrined in Article 12 ICESCR. Of note, the States mentioned reflect different levels of development. (see, UN Human Development Index: http://hdr.undp.org/en/ statistics)

[19] Website of the Office of the UN High Commissioner for Human Rights, *Monitoring the Economic, Social and Cultural Rights* <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx> (also cited in: <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRindex.aspx>.

[20] ICESCR, New York 16 December 1966, entered into force 3 January 1976, 993 UNTS 3, Article 16 § 1.

[21] Economic and Social Council (ECOSOC) Review of the Composition, Organization and Administrative Arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights, Resolution 1985/17 of 28 May 1985.

[22] The ICCPR established a monitoring body (i.e., the Human Rights Committee) and had an individual communications procedure through the OP to ICCPR since 23 March 1976 when it entered into force (OP to ICCPR, adopted by GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966), 999 UNTS 302). Note that until 2013 the CESCR had no opportunity to intervene and/or consider a violation of ESC rights of victims, due to the lack of an optional protocol authorizing the Committee to this end (OP to ICESCR, adopted by GA Res. A/RES/63/117, on 10 December 2008, entered into force on 5 May 2013).

Based on Articles 16-17 ICESCR and Article 12 ICESCR States parties are required to submit periodic reports to the Committee on the implementation of the right to health provision. Initially, submission must be done within two years of the entry into force of the Covenant for a particular State party (*initial report*), and thereafter every five years.[23] In order to facilitate the reporting process of States, the Committee has drawn up a set of reporting guidelines on the content of the state reports.[24] Specifically, the initial state report must provide information with regard to the country's situation and the measures taken by the respective State to ensure that the rights contained in the ICESCR, such as the right to health, can be enjoyed by everyone. The examination of the State's report by the Committee results in the adoption by the Committee of its CO, where both an interpretation of the ICESCR provisions that can be made operational within national context and State's compliance are provided.[25] Subsequent reports must show the progress made by the State in realizing the obligations undertaken in terms of the ICESCR, including updated information on adopted administrative, legislative and other measures, as well as steps taken to address issues raised by the Committee in its CO on the State party's previous report, or in its GCs.[26] Meanwhile, beyond the examination of State reports and the adoption of respective CO, the CESCR has also adopted a number of GCs to the ICESCR, among which a GC on the Right to Health adopted by the Committee in 2000.[27]

Thereto, an attempt will be made to elucidate the scope of 'all appropriate means' being subject to 'available resources' required by States for ensuring the right to health for all persons based on the work of the CESCR, namely on interpretative tools that the Committee has developed over time. These two clauses, 'all appropriate means' and 'available resources' are identified in the formulation of broad state obligations imposed by the ICESCR (Articles 2 § 1 and 12) and are further addressed by the Committee with respect to the realization of the right of all persons to health on the part of the State.[28]

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[23] Ibidem supra notes 19 and 20.

[24] Ibid; See, UN *Guidelines on Treaty-Specific Documents to be submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights*, CESCR, UN Doc. E/C.12/2008/2, 24 March 2009.

[25] See, also, UN CESCR, *General Comment No. 1: Reporting by States Parties*, UN Doc. E/1989/22, 27 July 1981.

[26] Ibidem supra note 24, UN Doc. E/C.12/2008/2, § 2.

[27] Between 1989 and June 2016 the CESCR adopted 23 GCs. The GCs of the CESCR are to be found in the UN website <www.ohchr.org/en/hrbodies/cescrindex.aspx>; As regards the normative interpretation of the right to health, contained in Article 12 ICESCR, see, Ibidem supra note 14, UN CESCR, GC No. 14.

[28] Of note, the CESCR has stressed that Article 2 ICESCR 'is of particular importance to a

(a) *'[...] by all appropriate means,* including particularly the adoption of legislative measures.'

The illustrative list of specific measures in Article 12 § 2 ICESCR, read in conjunction with the broad state obligation under Article 2 § 1 ICESCR, does not comprehensively determine the state measures to be appropriate for ensuring the effective enjoyment of the right to health by all persons within a State's jurisdiction.[29] Interestingly, as it is evident from the text, the ICESCR in its open-ended provision (i.e. Article 2 § 1) clearly places an emphasis on the adoption of legislative measures, as a way for States to realize ESC rights, like the right health. The CESCR has also recognised the essential role of legislative measures in certain instances of the realization process of ESC rights, such as in a case of protection against discrimination, as regards to vulnerable population groups, such as children and women and in the area of health.[30] The Committee has further suggested, albeit at a rather high level of abstraction, that States should consider the adoption of 'a framework law to operationalize their right to health national strategy' coupled with the establishment of national mechanisms for monitoring the implementation of the strategy and time bound targets as well as the development of appropriate benchmarks.[31]

Meanwhile, the CESCR has pointed out that the obligation to adopt legislative measures is 'by no means exhaustive of the obligations of States parties', which is also evident from the text in Article 2 § 1.[32] This means that legislation, namely

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full understanding of the Covenant and must be seen as having a dynamic relationship with all of the other provisions of the Covenant.'(GC No. 3 (infra note 30), § 1); At the CoE level, it is noteworthy that the ECSR in its case law has stipulated that state measures must be taken within reasonable time, within measurable progress and with the maximum of available resources. (see, e.g., Complaint No. 31/2005, *ERRC v. Bulgaria*, § 37)

[29] See, e.g., OP to ICESCR, GA Res 63/177 adopted on 10 December 2008, UN Doc. A/RES/63/117, 5 March 2009, annex, Article 8(4) which outlines that the CESCR, when considering the reasonableness of steps undertaken by a State to protect the rights under the ICESCR, 'shall bear in mind that the State Party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant'.

[30] UN CESCR, *General Comment No. 3: The Nature of States Parties' Obligations*, UN Doc. E/1991/23, 14 December 1990, § 3.

[31] Ibidem supra note 14, GC No. 14, § 56; UN CESCR, *Statement- An evaluation of the obligation to take steps to the "maximum of available resources" under an optional protocol to the Covenant*, UN Doc. E/C.12/2007/1, 10 May 2007, § 11.

[32] Ibidem supra note 30, GC No. 3, § 4. It is noteworthy that other appropriate measures involve administrative, financial, judicial, social and educational measures. (see, UN CESCR, GC No. 3, § 5 and 7); UN CESCR, General Comment No. 9: *The Domestic Application of the Covenant*, 3 December 1998, UN Doc E/C.12/1998/24, §§ 3-5 and 7.

incorporation of ESC rights, like the right to health, in domestic legal systems, is not the only measure considered 'appropriate' and required of States by which to realize these rights and, to that end, States retain a margin of discretion.[33] Here it must be conceded that this discretion in the selection of the means by the States is not unlimited as the CESCR has generally argued that 'while each State party must decide for itself which means are the most appropriate … with respect to each of the rights, the 'appropriateness' of the means chosen will not always be self-evident. It is therefore desirable that States parties… should indicate not only the measures that have been taken but also the basis on which they are considered to be the most 'appropriate' under the circumstances'.[34] In other words, in recognition of the diverse circumstances of legal and administrative systems within each State, States are afforded this margin of discretion -albeit within boundaries-.[35] Nonetheless, these general assertions of the CESCR leave open the critical question as to what kind of measures (e.g., legislative and/or administrative measures etc.) will be deemed appropriate to ensure the realization of the right to health, which is yet to be clearly answered by the Committee.

Of assistance perhaps -albeit objections have been expressed by scholars[36]- can be the application of the 'reasonableness test', as outlined by the CESCR with regard to the communications procedure under the Optional Protocol to the ICESCR. Accordingly, the CESCR shall consider the reasonableness of the measures taken by States.[37] The 'reasonableness' of the measures is qualified by a number of general factors that provide a broad framework of steps to be taken

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[33] See, ibid., GC No. 9, § 9. The CESCR notes the 'broad and flexible approach' of Article 2 § 1 ICESCR.

[34] Ibidem supra note 30, GC No. 3, § 4; Ibidem supra note 14, GC No. 14, § 53.

[35] Ibidem supra note 32, GC No. 9, § 1; Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 11. Accordingly, the Committee has acknowledged that the evaluation of the obligation under Article 2 § 1 ICESCR will always respect 'the margin of appreciation of States to take steps and adopt measures most suited to their specific circumstances'.; See also, other authoritative sources, e.g., 'Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' 22-26 January 1997, UN Doc. E/C.12/2000/13, 2 October 2000, Guideline 8.; See also, supra note 11, M. Sepúlveda 2003, p. 339.

[36] See, e.g., Br. Griffey, 'The "Reasonableness" Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights', *Human Rights Law Review* 2011, 11(2), pp. 275-327, p. 319. He maintains that appropriateness, as a legal standard, sets a higher bar than 'reasonableness', in that it may require budgetary prioritization and optimization.

[37] Article 8 § 4 of the OP to ICESCR (OP to ICESCR, adopted by GA Res. A/RES/63/117, on 10 December 2008, entered into force on 5 May 2013).

to achieve this requirement. Hence, the Committee would consider factors, including the adoption of deliberate, concrete and targeted measures; the non-discriminatory and non-arbitrary manner in the selection of means; the prioritization of measures targeted to the most vulnerable groups; the time frame in which steps were taken; the allocation of available resources in accordance with human rights standards, as will be explained further below.[38] Further, the Committee would consider whether the State has adopted the least restrictive measure where there is a range of alternative policy options.[39] It is within this context that the Committee has acknowledged and considered the level of development of a respective State (i.e., domestic circumstances) for the purpose of evaluating the reasonableness of the measures taken and ensuring a context-sensitive interpretation of such measures.[40] However, in literature it is argued that an engagement with relevant domestic jurisprudence can provide considerable means by which to elucidate the notion of 'reasonableness', which could complement the abstract view taken by the Committee when applying this notion.[41]

In any case, it is important to note that whatever measures adopted by a State these must contribute to the effective realization of its right to health obligations within its jurisdiction.[42] As such, the appropriateness of the State measures is largely associated with the effectiveness requirement, albeit the assessment of which is not explicitly elucidated in the work of the CESCR.[43] Indeed, in literature

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38 Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 8 (b) and (f); Ibid., Article 8 § 4 OP to ICESCR.

39 Ibid., § 8(d); Ibid., Article 8 § 4 OP to ICESCR.

40 See, e.g., UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 8, UN CESCR, CO: Angola, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, § 26; For a similar approach as regards to all ESC rights, see also, supra note 11, M. Sepúlveda 2003, p. 337.

41 Ibid., M. Sepúlveda 2003; See, e.g., the decision of the South African Constitutional Court in *Grootboom and Others v. The Government of the Republic of South Africa and Others*, Case No: CCT 11/00, 4 October 2000, §§ 39-44. The court's decision further elaborates on the notion of reasonableness requirement. Accordingly, in light of the reasonableness requirement, the measures must: i. ensure appropriate financial and human resources, ii. be coordinated, comprehensive and coherent, iii. be reasonable both in their conception and implementation, iv. be context-sensitive, balanced, flexible and make provision for short, medium and long term needs and v. address the most urgent needs and respond to the needs of the most vulnerable.

42 Ibidem supra note 32, GC No. 9, § 5.

43 Ibidem supra note 11, M. Sepúlveda 2003, p. 337; Ibidem supra note 30, GC No. 3, § 4; See, also, other authoritative sources, e.g., 'The Limburg Principles on the Implementation of the ICESCR', UN Doc. E/CN.4/1987/17, § 20 (also available at: *Human Rights Quarterly* 1987, 9(2), pp. 122-135).

it is submitted that the Committee has not established a clear test to assess the effectiveness of the measures (administrative and others) taken by States.[44] The Committee has, however, hinted at the effectiveness requirement for example in its report for Greece, where it recommended that the State party, 'take *effective measures* to ensure that there are sufficient health-care professionals, including mental-health staff, to meet the demands in medical treatment'[emphasis added].[45]

In the meantime, the scope of appropriate means for effective realization of the right to health is likely to be also informed by the CESCR's approach foreshadowed in its reporting guidelines drawn up to facilitate States in preparing their reports under ICESCR. Under these guidelines States are expected to indicate whether they have 'adopted a national health policy and whether a national health system… is in place'.[46] It is worth bearing in mind that the CESCR in GC No. 14 has also set out a number of parameters to guide States and ensure the effective implementation of a national health policy.[47] Such a policy should *inter alia* 'be based on the principles of accountability, transparency and independence of the judiciary' and facilitate people's participation.[48] The CESCR has also provided a number of guideposts for policy action, framed in terms of priority areas that should be integrated in the realization process. Such priority areas are also identified by the CESCR in its GC No. 14 and cover a wide range of health-related topics (i.e., access to healthcare and underlying determinants of health) that needs to be addressed by States, such as child and maternal health (pre-and post-natal care and emergency obstetric services), immunization against infectious diseases, prevention, treatment and control of diseases linked to water and access to adequate sanitation etc.[49]

Nevertheless, one may argue that aside from setting out a broadly-based (unworkable at times) process to be followed by States, it would be advisable for

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44 See, e.g., Ibidem supra note 11, M. Sepúlveda 2003, p. 337.

45 UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 36(b).

46 UN CESCR, *Guidelines on Treaty-Specific Documents to be submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/C.12/2008/2, 24 March 2009, annex, § 55; Note that the adoption of a national health policy is also addressed by the CESCR in its GC No. 14 as state's minimum requirement for ensuring the enjoyment of the right to health under all circumstances (GC No. 14, §§ 43(f) and 53; See, also, UN CESCR, GC No. 1 (note 25), § 4; UN CESCR, General Comment No. 5: *Persons with disabilities*, UN Doc. E/1995/22, 9 December 1994, § 13).

47 Ibidem supra note 14, GC No. 14, §§ 53-56.

48 Ibidem supra note 14, GC No. 14, §§ 54-55.

49 Ibidem supra note 46, UN Doc E/C.12/2008/2, §§ 56-57; Ibidem supra note 14, GC No. 14, §§ 12(b) and (d), 14, 16, 21-23, 43(d) and 44 (a), (b) and (e).

the Committee to concretely specify some principal health measures required by States in virtue of the progressive nature of the right to health and resource availability (see section 3.4). On the other hand, Toebes pointedly argues that this might be problematic in that the focus on particular issues, for example on health care issues, might ignore other health-related topics often just as significant for the enhancement of people's health.[50] Thereto, the argument made here is that a balanced, workable and complete perspective (i.e., primarily suited to the particular circumstances and challenges of each State) on the definition of State measures is required on the part of the Committee (e.g., in its CO). This could actually guide and direct States to set concrete (policy) priorities and tangible targets, after careful planning, upon which they can be held accountable, while at the same time avoiding inefficient use of resources and corruption (see section 3.7.2).

Such an argument can be advocated when looking, by way of example, at the approach -albeit general at times- taken by the Committee to address the health needs of vulnerable population groups. While the ICESCR does not explicitly stipulate that priority attention should be given to people belonging to disadvantaged or marginalized population groups, the CESCR has taken a different view in its GCs and CO. In a relatively general sense, the Committee has confirmed that States must give special consideration and adopt targeted measures that respond to the health needs of such groups.[51] At the same time, the Committee has declared that States have a special obligation to provide those who do not have sufficient means with necessary health insurance and healthcare facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care.[52] Meanwhile, in a particular sense, in its GC No. 20 the Committee has also

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[50] B.C.A. Toebes *The Right to Health as a Human Right in International Law*, Antwerp/ Oxford: Intersentia/ Hart 1999, p. 143.

[51] Ibidem supra note 14, GC No. 14, §§ 18-27 (Note also that the Committee has drawn attention on the health needs of certain vulnerable population groups within society, such as women, children and adolescents, older persons, persons with disabilities and indigenous peoples.); See, also, supra note 31, UN Doc. E/C.12/2007/1, § 8(f); For similar interpretations to that of CESCR that support the prioritization of vulnerable groups on the part of the State, see also other authoritative sources, including 'the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights' (UN Doc. E/CN.4/1987/17, supra note 43) and 'the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (UN Doc. E/C.12/2000/13, supra note 35).

[52] Ibidem supra note 14, GC No. 14, § 19; The Committee's approach finds support in the Limburg Principles which provide that 'special measures should be taken to advance the interest of certain groups in order that these groups enjoy the full benefit of economic, social and cultural rights' (supra note 43, §§ 36 & 39).

set out a non-exhaustive list of various vulnerable groups, being included within the scope of non-discrimination in the enjoyment of ESC rights, including the right to health. Specifically, the Committee affirmed that the rights set out in the Covenant apply to every person, including non-nationals, refugees, asylum-seekers, stateless persons, migrant workers and victims of trafficking, irrespective of legal status and documentation.[53]

In its CO the CESCR has on occasions identified the precarious situation and the need for prioritization in the area of health of vulnerable groups of the population which differ per country. This is clear in a few examples of the CESCR's work in particular countries that are mentioned below. For instance, the Committee has acknowledged 'the limited access to health services in particular in rural areas'[54] and has also expressed its concern with respect to the fact that minorities, particularly the Roma and the Turkish populations continue to be the victims of discrimination, particularly in the area of health[55] accompanied with -albeit general- recommendations that the State 'guarantee adequate access to health services'.[56] Likewise, the CESCR has also recommended that States 'provide health care to the most marginalized children and families'[57], 'take effective and appropriate measures to ensure that street children have access to …health care' and 'ensure the equitable availability of health-care facilities, particularly obstetric facilities, among the economically disadvantaged populations.[58] The CESCR has also called upon States to '(b) increase health-care funding for disadvantaged populations' as well as '(c) ensure that the people living in poverty have access to free primary health care'.[59]

All in all, it can be observed that the CESCR has tended to provide insight and recommendations slightly oriented as to the type of measures required of States to address, *inter alia*, the precarious position of certain population groups in relation to their right to health and access to health care. Nonetheless, some indications

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53 UN CESCR, General Comment No. 20: *Non-Discrimination in Economic, Social and Cultural Rights*, UN Doc. E/C.12/GC/20, 2 July 2009, § 30.

54 UN CESCR, CO: Albania, UN Doc. E/C.12/ALB/CO/2-3, 18 December 2013, § 32; CO: the Republic of the Congo, UN Doc. E/C.12/CO/Add.45, 23 May 2000, § 28.

55 UN CESCR, CO: Slovakia, UN Doc. E/C.12/SVK/CO/2, 8 June 2012, § 9; See, also UN CESCR, CO: Bulgaria, UN Doc. E/C.12/BGR/CO/4-5, 11 December 2012, § 7.

56 UN CESCR, CO: Bulgaria, UN Doc. E/C.12/BGR/CO/4-5, 11 December 2012, § 7.

57 UN CESCR, CO: Albania, UN Doc. E/C.12/ALB/CO/2-3, 18 December 2013, § 12.

58 UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 12 June 2009, § 24(b) and 28(e).

59 UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 12 June 2009, § 28 (b), (c); See, e.g., UN CESCR, CO: Gabon UN Doc. E/C.12/GAB/CO/1, 27 December 2013, § 12, 29, CO: Angola, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, § 36, CO: Benin, UN Doc. E/C.12/1/Add.78, 5 June 2002, § 43.

still can be discerned from the work of the CESCR. Thereto, one may argue that the CESCR has intended to avoid opening a detailed discussion as to what constitutes 'all appropriate means' in preference for expressions of concern accompanied with rather broad recommendations at times. Nevertheless, some could argue that such broadly-based approach of the CESCR rests on: i) the recognition of the margin of appreciation for States and ii) the need to ensure the implementation of context-sensitive measures owed to particular circumstances and challenges within each State (e.g., economic austerity, economic surveillance, embedded health inequalities, vulnerable groups etc) (see also section 4.2.2).[60]

(b) '[…] to the maximum of its available resources…'

On the basis of the work of the CESCR, the preceding section attempted to identify the scope of state measures that are considered appropriate for realizing the right to health. At the same time it must be conceded that all of the measures required by a State are subject to the resources available to the respective State, namely 'to the maximum of available resources'.[61] In general, the clause 'to the maximum of its available resources' implies that the scope of these resources involves not simply financial, but a range of resources, required of States in the realization process.[62] A similar view is taken by the CESCR in its CO without, though, defining in detail the meaning of 'available resources' and the 'maximum' of these resources available to a State in question at a given time. For instance, beyond financial resources, the Committee has generally identified on several occasions that States, especially the developing ones, are required to ensure sufficient human resources, in order to realize the right to health of all persons within their jurisdictions, such as recruitment of an adequate number of skilled health care professionals available both in rural and urban areas in a country.[63] Moreover, at a rather abstract level

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[60] An analogous approach is adopted in the recommendations of the CRC Committee and the CESCR on the fulfillment of a particular state obligation to diminish infant and child mortality, see, J. Tobin, *The Right to Health in International Law*, Oxford: Oxford University Press 2012, p. 258.

[61] Article 2 § 1 ICESCR.

[62] See, authoritative sources, e.g., the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (supra note 35), Guideline 10 (a reference is made to the 'availability of adequate financial and material resources'); The Limburg Principles on the Implementation of the ICESCR (supra note 43), § 24 (a reference is made to 'the development of societal resources').

[63] See, e.g., UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 78; UN CESCR, CO: Gabon, UN Doc. E/C.12/GAB/CO/1**,** 27 December 2013, § 28; CO: the Republic

the CESCR has affirmed that a State's available resources involve 'both the resources existing within a State and those available from the international community through international cooperation and assistance'.[64] A striking example thereof perhaps constitutes the WHO, which under its Constitution is responsible, *inter alia*, for providing technical support to countries (see Part II, section 6.4.4).[65]

In the meantime, like the progressive realization clause (section 3.4), the clause of available resources may be used as an excuse by States for delaying and ultimately for not complying with their right to health obligations.[66] In virtue of the variance in the socio-economic conditions and level of development, States are given a margin of discretion -albeit not unlimited- in the evaluation of what resources are considered to be available.[67] The CESCR has the potential to assess the degree of a State's compliance with the obligation under Article 2 § 1 ICESCR on a State-by-State basis and, particularly, assess whether or not a State's assertion of resource scarcity is well-founded. In its Statement on maximum available resources the Committee has set out a number of criteria for such assessment, which are relevant for the justification of retrogressive measures (section 3.4):

(a) The country's level of development;
(b) The severity of the alleged breach;
(c) The country's economic situation, in particular whether the country was undergoing a period of economic recession;
(d) The existence of other serious claims on the state's limited resources (e.g. natural disasters);
(e) Whether the State had sought to identify low-cost options and
(f) Whether the State had sought cooperation and assistance.[68]

In light of the above criteria, we may conclude that the absence of a State's justification for the adoption of a legislation or policy that constitutes a step back

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of the Congo, UN Doc. E/C.12/1/Add.45, 23 May 2000, § 28; See, other authoritative sources, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN General Assembly, 60th Sess., Agenda Item 73(b),* UN Doc A/60/348, 12 September 2005, §§ 27-29.

64 Ibidem supra note 30, GC No. 3, § 13; Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 5; Ibid., e.g., CO: the Republic of the Congo, § 28; See, also, Part II, section 6.4.4, Greece signed an agreement with WHO for the purpose of planning a health care reform.

65 Article 2 (d) WHO Constitution.

66 M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, p. 138.

67 Ibid., pp. 136-137.

68 Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 10.

in the level of protection of the right to health, i.e. a reduction of public health expenditure, can be construed as a State's non-compliance with its right to health obligations. Here, it is essential to dissociate a State's unwillingness to comply with its right to health obligations under Article 12 ICESCR from a State's incapacity to do so.[69] A State's unwillingness implies a lack of commitment to meet the respective obligations under the right to health, especially in terms of making every effort to use effectively all available resources at its disposal for that purpose due to resource constraints. In its GC No. 14 the CESCR has strictly declared that a State's unwillingness can constitute a violation of the right to health.[70]

Whilst the above criteria provide a useful textual basis and draws a conceptual picture of the Committee's approach on State obligations in light of their available resources, it must be recognized that an accurate assessment of a State's situation by the Committee requires more considered attention in relation to the calculation of the maximum of a State's available resources at a given time. Instead, the CESCR has tended to adopt a somewhat haphazard approach in its CO on several Country Reports. Several of its comments in its CO are expressions of general exhortations and concern. For instance, the Committee has regularly urged States 'to significantly increase its healthcare expenditure'[71] and to 'increase expenditure for health care and … ensure universal access to health care at prices affordable to everyone'.[72] Moreover, the Committee has expressed concern that 'despite the economic growth achieved … health-care expenditures remain exceptionally low … and that a significant proportion of the population continues to have limited or no access to basic health services, resulting in alarmingly high rates of maternal and infant mortality, as well as high incidences of tuberculosis and other communicable diseases'.[73] The Committee has, however, hinted at a sustainable funding for health in its CO for particular countries where it noted the inadequate management and misallocation of resources in cases where the expenditure for military defense was to the detriment of health expenditure and other social expenses.[74]

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69 Ibidem supra note 14, UN CESCR, GC No. 14, § 47.

70 Ibid.

71 See, e.g., UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 73; UN CESCR, CO: Albania, UN Doc. E/C.12/ALB/CO/2-3, 18 December 2013, § 32.

72 UN CESCR, CO: the Republic of Korea, UN Doc. E/C.12/KOR/CO/3, 29 November 2009, § 30; See, also, UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 29 May 2009, § 28(b).

73 UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 33; See, e.g., UN CESCR, CO: Philippines, UN Doc. E/C.12/PHL/CO/4, 1 December 2008, § 17.

74 See, e.g., UN CESCR, CO: Democratic Republic of Congo, UN Doc. E/C.12/COD/Q/5, 17 November 2009, § 16; CO: Philippines, UN Doc. E/C.12/1995/7, 7 June 1995, § 21.

Nonetheless, the CESCR slightly offers any real insight as to the calculation of the maximum of a State's available resources (see also Grover's argument in below section 4.2.3). This implies that a detailed analysis of the relevant information is needed on the part of the Committee, provided the Committee has sufficient access to it from State reports (i.e., complete and reliable data) as well as a good knowledge of each country's situation (e.g., evidence-based evaluation reports from NGOs). In this respect, in literature, it is maintained that the supervision of a State's compliance is complex and raises legitimate concerns about the capability of the CESCR to respond at its supervisory role in an effective manner.[75] Thereto, it is submitted, for instance, that domestic courts could undertake the task of monitoring and supervising the adoption of retrogressive measures that affect the enjoyment of the right to health in the country in question.[76]

Meanwhile, when a State's available resources are scarce, the CESCR has tended to adopt a relatively weak approach by stressing that 'the obligation remains for a State party *to strive* to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances' [emphasis added].[77] It has, however, recognised that 'even in times of severe resources constraints whether caused by a process of adjustment, of economic recession, or by other factors the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes'.[78] It has also alluded to sufficient resource allocation with a primary focus on certain population groups in several of its CO on respective Country Reports, where for example, it generally urged States to increase 'its budget allocation for health'[79] and/or health-care funding in particular for disadvantaged population groups.[80]

Last but not least, we may conclude that the CESCR's work, primarily as regards its response to State reports, rather than elucidate in detail what constitutes 'the maximum of its available resources' has been confined to expressions of concern accompanied with general calls for action and recommendations to the

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75 See, for a general approach as regards to all ESC rights supra note 11, M. Sepúlveda 2003, p. 316.

76 Ibid., p. 332.

77 Ibidem supra note 30, UN CESCR, GC No. 3, § 11.

78 Ibid., § 12.

79 UN CESCR, CO: Poland, UN Doc E/C.12/POL/CO/5, 2 December 2009, § 29; CO: Angola, UN Doc E/C.12/AGO/CO/3, 20 November 2008, § 26.

80 See, e.g., UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 12 June 2009, § 28(b); CO: Benin, UN Doc. E/C.12/1/Add.78, 5 June 2002, § 29; CO: Tajikistan, UN Doc. E/C.12/TJK/CO/1, 23 November 2006, § 70; CO: Angola, UN Doc. E/C.12/AGO/CO/3, 20 November 2008, §§ 29, 37; CO: Kenya, UN Doc. E/C.12/KEN/ CO/1, 19 November 2008, § 32.

respective States. Such an approach is slightly directed as to elucidating the nature of the resources, let alone the amount of those required by States. (see also Grover's argument in below section 4.2.3). Nonetheless, in defence of the CESCR's approach one may maintain the position that despite its general approach at times, the Committee has attempted to concretely address a State's assertion on resource availability by developing a number of criteria for its assessment in its Statement on maximum available resources. As such, Tobin argues that the position advanced by the Committee reflects 'a dynamic understanding' of the phrase available resources, whereas human rights monitoring bodies, such as the CESCR, do not seek 'to impose or demand the adoption of a mathematical formula by states' as regards the resources allocated to health.[81] At the same time it must be perhaps conceded that still a principal indication as to the amount of resources to be allocated to health based on the distinct circumstances of each State should be provided by the Committee in its CO (see below section 4.2.3).

4.2.2. UN COMMITTEE ON THE RIGHTS OF THE CHILD

The Committee on the Rights of the Child -formed by an international treaty, the CRC- (henceforth: CRC Committee) is the UN body of 18 independent experts that monitors the implementation by the State parties of the right to health (Article 24 CRC), among other rights enshrined in CRC.[82] In particular, pursuant to Article 43 CRC, for the purpose of examining the progress made by States parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a CRC Committee, which shall carry out the functions hereinafter provided. As such, under Article 44 CRC in conjunction with Article 24 CRC on the right to health, States parties must regularly submit to the Committee reports on the measures they have adopted which give effect to the right to health and on the progress made on ensuring the respective right within two years after ratification of the Convention and then every five years. The reports made under the Article 44 CRC shall indicate factors and difficulties, if any, affecting the degree of fulfillment of the obligations under Article 24 CRC. With respect to Article 24 CRC, the CRC Committee reviews the States parties' periodic reports as well as

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[81] Ibidem supra note 60, J. Tobin 2012, pp. 229 and 253.

[82] Convention on the Rights of the Child, New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3; Website of the Office of the UN High Commissioner for Human Rights, *Monitoring Children's Rights* <http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIntro.aspx>; See generally, G. Lansdown, 'The Reporting Process under the Convention on the Rights of the Child' in: P. Alston & J. Crawford, *The Future of UN Human Rights Treaty Monitoring*, Cambridge: Cambridge University Press 2000, pp. 113-128.

the complementary reports of those States parties to the optional protocols and on the basis of this examination produces a document with its Concluding Observations (henceforth: CO), where the CRC Committee addresses its concerns and recommendations in respect of individual States parties.[83]

Meanwhile, the CRC Committee publishes its interpretation of the content of human rights provisions, known as General Comments (henceforth: GCs) on thematic issues of general interest or on its methods of work as well as General Recommendations, following days of general discussion (e.g. on violence against children). The CRC Committee has been active in producing GCs relating to the right to health.[84] The CRC Committee, for example, in its GC No. 4 enunciates a specific interest in applying human rights protection to children, including the protection of the right to health. Most importantly, though, in its GC No. 15 the Committee offers an interpretation of Article 24 CRC on the right of the child to the enjoyment of the highest attainable standard of health. The CRC Committee, in its GC No. 15, has interpreted Article 24 CRC with respect to monitoring States' compliance, as requiring States to take measures to protect the right to health of children. Particularly, a State must provide certain data on the health status of children to the CRC Committee. Moreover, a State must demonstrate that it is taking steps to ensure that it adequately invests in the health of children. Additionally, a State must take steps to ensure that the health of all children is respected and protected. Individual State compliance with these actions and other obligations is reviewed by the CRC Committee, when States submit their periodic reports.[85] Accordingly, an attempt to identify the nature of state measures required for ensuring the right to health for all children beyond the specific measures that are listed in Article 24 CRC will be made based on the work of the CRC Committee which derives from its GCs as well as observations and recommendations made

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83 Ibid.

84 Ibid. In general, between 2001 and June 2016 the CRC Committee adopted 18 GCs, available at <www.ohchr.org/EN/HRBodies/CRC>. The GCs relating to the right to health are, *inter alia,* No. 3: HIV/AIDS and the rights of the child; No. 4: Adolescent health and development; No. 7: Children's rights in early childhood; No. 9: The rights of children with disabilities; No. 12: The right of the child to be heard. Most significantly, in 2013 the CRC Committee adopted GC No. 15 on children's right to health.

85 UN CRC Committee, General Comment No. 15: *The right of the child to the enjoyment of the highest attainable standard of health (art. 24),* UN Doc. CRC/C/GC/15, 17 April 2013, §§ 74, 104, 117-118; See also, UN CRC Committee, General Comment No. 5: *General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)*, UN Doc. CRC/GC/2003/5, 27 November 2003.

on the country reports. In the following paragraphs the scope of two clauses, outlined previously, that are also found in the CRC and are recommended by the CRC Committee with respect to the fulfillment of the general obligation to guarantee the right to health for all children on the part of the State will be briefly analysed.

But first, the definition of children and four general principles will be provided that are addressed in the recommendations made by the CRC Committee regarding the implementation of the right to health of the child. Accordingly, the CRC Committee has adopted three main classifications concerning the definition of children on the basis of their age, covering early childhood, middle childhood and adolescence.[86] In particular, the CRC Committee 'proposes as an appropriate working definition of early childhood the period below the age of 8 years', namely 'all young children: at birth and throughout infancy; during the preschool years; as well as during the transition to school'.[87] Moreover, 'middle childhood' covers the period after the child's transition to school is made until the time the child is on the verge of adolescence.[88] Adolescence is the period following middle childhood that proceeds adulthood.[89] Notably, along with the above classification, the CRC acknowledges in Article 5 the responsibilities, rights and duties of both parents (or other persons legally responsible for the child) 'to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention' as well as in Article 18 their primary responsibility for the upbringing and development of child.[90] These provisions highlight the role of both parents (or other persons legally responsible for the child), in circumstances where a child has not attained capacity and competency, in ensuring the child's rights, including the right to health in the context of their primary responsibility for ensuring healthy living conditions and guiding the child within health care settings in line with the child's best interests. Of note, the role of parents in realizing the right to health of the child is specified by the CRC Committee in its GC No. 15.[91]

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[86] UN CRC Committee, General Comment No. 7: *Implementing Child Rights in Early Childhood,* UN Doc. CRC/C/GC/7/Rev.1, 1 November 2005, § 8; See also, supra note 60, J. Tobin 2012, p. 219.

[87] Ibid., GC No.7, §§ 1-4.

[88] Ibid., § 8.

[89] Ibid., § 8; UN CRC Committee, General Comment No. 4: *Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, 1 July 2003, § 2.

[90] Ibidem supra note 82, Articles 5 & 18 CRC.

[91] Ibidem supra note 85, GC No. 15, § 78.

Meanwhile, in terms of conceptualizing the nature of the state obligation to realize the right to health for all children under Article 24 CRC, it is important to take into account other articles of the CRC, which are also considered in the observations and recommendations of the CRC Committee. Hence, we will briefly refer to the content of four general principles of the CRC, namely to the principles of best interest of the child, non-discrimination, survival and development, and participation, enshrined in CRC.[92] It is notable that these four principles, which constitute also rights set forth in the CRC, are identified as key principles by the CRC Committee, that have the potential to be applied to the interpretation of every child's right to health with the aim of guiding respective national policies towards the effective realization of the right to health.[93]

More specifically, in view of both Articles 3 and 24 CRC the best-interests principle should be a 'primary consideration' in all decision-making concerning children's health and in relation to health services (for instance, in cases dealing with waiting lists for medical treatment).[94] Nonetheless, caution must be exercised when developing and applying measures based on the best-interests principle, in that its broad interpretation could justify the application of even (traditional) practices prejudicial to the health of children.[95] In addition, the non-discrimination principle under Article 2 CRC requires children to be protected against discrimination on any ground (or a combination of grounds), including discriminatory practices on the basis of the status of their parent(s), carer(s) or other family member(s), ethnic origin, personal circumstances and lifestyle in the

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92 Ibidem supra note 85, GC No. 5, § 12.

93 The CRC Committee identified the principles of best-interests of the child, non-discrimination, survival and development, and participation as general principles in 1991 in terms of States' reporting on the realization of the rights contained in the CRC (UN Doc. CRC/C/5, 30 October 1991, § 13); See also, e.g., UN CRC Committee, GC No. 7 (supra note 86), § 13(b); For instance, see, *inter alia*, UN CRC Committee, CO: Greece, where the CRC Committee uses these principles as evaluating tools with respect to the protection of the children's right to health.

94 Ibidem supra note 82, CRC 1990; Ibid. Note that the best-interests principle is widely recognized within human rights law. For instance, the ECSR has stressed that 'when ruling on situations where the interpretation of the Charter concerns the rights of a child, the Committee considers itself bound by the internationally recognized requirement to apply the best interests of the child principle' (*Defence for Children International (DCI) v. The Netherlands,* Complaint No. 47/2008, 27 October 2009, § 29).

95 S.I. Spronk-van der Meer, *The Right to Health of the Child: An Analytical Exploration of the International Normative Framework*, Antwerp: Intersentia 2014, pp. 56-58 (citing relevant studies).

area of access to health care (see Part II, section 7.3.4). This principle is also evident in the wording of Article 24 § 1 CRC which stipulates that States shall strive to ensure that *no child* is deprived of access to health care [emphasis added].[96] Within the context of health care, for example, discriminatory practices against children due to their increased vulnerability (i.e., in the first place as persons below the age of 18) compared to other age groups in society may result in a disproportionate negative impact on their health. For this reason, the CRC Committee has generally noted that States are required to identify the factors which disadvantage certain groups of children and address them through the development of respective laws and policies.[97]

Moreover, the principle of survival and development laid down in Article 6 CRC should be considered in conjunction with health-related decisions of parents, such as the weak level of birth registration, coupled with the need for access to preventive care for children.[98] On many occasions, for instance, within the context of health care, the lack of official identity documents, namely birth registration, denies children their participation in vaccination programmes and access to regular health check-ups, and hinders access to early childhood development services and social benefits in general (see Part II, section 8.3.3).[99] This situation, in turn, results in affecting negatively life prospects and development of children and increases the risks to their survival and development. Furthermore, in view of Articles 5 and 12 § 1 CRC, children should have a say in health-related decisions affecting them in accordance with their age and level of maturity.[100] The principle of participation

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96 Ibidem supra note 82, CRC 1990.

97 Ibidem supra note 85, GC No. 15, § 11.

98 Ibidem supra note 82, CRC 1990; The linkage between Articles 6 and 24 is stipulated in the CRC Committee's general guidelines for the form and content of periodic reports, particularly under the section 'basic health and welfare'. See, UN CRC Committee, *General Guidelines Regarding the Form and Content of Periodic Reports*, 39th sess., UN Doc. CRC/C/58/Rev.1, 2005, § 31; Ibidem supra note 85, GC No. 15, § 18.

99 Ibidem supra note 86, GC No. 7, § 25; See, e.g., UN CRC Committee, CO: Romania, UN Doc. CRC/C/15/Add.199, 18 March 2003, § 32; UN CRC Committee, CO: the Former Yugoslav Republic of Macedonia, UN Doc. CRC/C/15/Add.118, 23 February 2000, § 21; UN CRC Committee, CO: the Former Yugoslav Republic of Macedonia, UN Doc. CRC/C/MKD/CO/2, 23 June 2010, §§ 32-33; UN CRC Committee, CO: Mexico, UN Doc. CRC/C/MEX/CO/3, 8 June 2006, § 32; UN CRC Committee, CO: Sudan 2010, UN Doc. CRC/C/SDN/CO/3-4, 22 October 2010, § 38; UN CRC Committee, CO: India, UN Doc. CRC/C/15/Add.228, 26 February 2004, § 39.

100 Ibidem supra note 82, CRC 1990; Ibidem supra note 85, GC No. 15, § 19; See, e.g., UN CRC Committee, CO: Zambia, UN Doc. CRC/C/15/Add.206, 2 July 2003, § 51(c).

can contribute to the reduction of fear and enhancement of understanding among children within healthcare settings.[101] It is in this context that the CRC Committee has pointedly noted that 'interventions have been found to benefit children most when they are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as objects for whom decisions are made'.[102] Nevertheless, at this stage, it is important to note that the principle of participation should be applied in combination with Article 5 CRC, namely the evolving capacities of the child, especially with regard to younger children. This means that in circumstances where children have not attained capacity, the parents (or other care-takers/persons legally responsible for the child) acting on behalf of those children must strike a right balance between those children's involvement in the decision-making process related to their health in line with Article 12 CRC and their primary responsibility to ensure the best interests of those children consistent also with Article 18 CRC.

All in all, the aforementioned four principles offer a normative framework and perhaps a tool for State's action in that they prescribe standards about the health process required for the treatment of children in a State's jurisdiction. Hence, it must be conceded that these principles should be translated into the content of the broad state obligation to realize the right to health of the child and given effect in relevant national health legislation and policies. Nevertheless, in light of the preceding analysis, when applying these principles, caution must be exercised against conflating their scope to justify the application of practices prejudicial to children's health, as mentioned earlier.

Accordingly, the Committee recommended that the respective state party 'involve children in formulating and implementing preventive and protective policies and programmes'; Likewise, the CESCR in its GC No. 14 (supra note 14, § 23) has recognised that children's participation is significant for the adoption of appropriate measures to secure their healthy development.; For relevant to the principle of participation provisions in human rights documents with respect to the protection of health, see, also, Annex 1.

101 Importantly, the principle of participation under Article 12(1) CRC should be applied in conjunction with Article 5 CRC (the evolving capacities of the child), which can help in determining the capacity of children to participate meaningfully in the decision-making, namely strike a right balance between children's autonomy in the decision-making and their protection from deciding against life-saving treatments; See also, for the involvement of beneficiaries in determining the nature of measures required for realizing their right to health, J. Tobin 2012 (supra note 60), p. 161.

102 UN CRC, General Comment No. 3: *HIV/AIDS and the Rights of the Child*, UN Doc. CRC/GC/2003/ 3, 17 March 2003, § 12.

(a) '[...] all appropriate legislative, administrative, and other *measures* for the implementation of the rights recognized in the present Convention… *'*

Under Article 4(1) CRC in conjunction with Article 24 CRC, the realization of the right to health requires a State to identify and undertake all appropriate measures to secure the effective enjoyment of the right to health for all children within its jurisdiction (see section 2.2.2). The same obligation stems from Articles 2 § 1 and 12 ICESCR, as elaborated in section 4.2.1. Along with the general obligation in Article 4(1), the right to health provision, Article 24 § 2 CRC, provides that the measures adopted by a State must be 'appropriate' as well as sets forth a list of illustrative and specific measures. Several relevant indications can be detected in the GCs, CO and other documents of the CRC Committee -albeit at a rather high level of obscurity as to what kind of measures the Committee considers to be 'appropriate'. In this regard, a few examples are cited subsequently.

In particular, an elaboration -even though limited- of the appropriate measures listed in Article 24 § 2 can be found in GC No. 15. For instance, the CRC Committee has argued that the right to health of all children within the context of health care cannot be restricted beyond the provision of primary health care to only emergency care, as in the case of adults. The Committee has further stressed that States are under the obligation to ensure universal coverage of quality primary health care including prevention, health promotion, care and treatment services, and essential drugs under all circumstances in the context of fulfilment of their core obligations under every child's right to health.[103] Nonetheless, the Committee has failed to detail in full the actual meaning and implementation of primary health care, whose nature has been controversial and contentious ever since its emergence (see section 2.2.3).[104]

More broadly, the CRC Committee provides some guideposts on the nature of the implementation measures in its GC No. 5.[105] These primarily include:

(a) Legislative measures requiring a comprehensive review of all (proposed and existing) domestic legislation and the recognition of the CRC within domestic legal systems (i.e., its status in relation to its applicability before national

[103] Ibidem supra note 85, GC No. 15, § 73(b); In this regard, the CESCR has stressed that States are under the obligation to provide essential primary health care to every person under all circumstances in the context of fulfillment of their core obligations under the right to health. (UN CESCR, GC No. 14 (supra note 14), § 43 & GC No. 3 (supra note 30, § 10) (see section 3.4); Further, the CESCR has noted that the provision of child health care constitutes an obligation of comparable priority (§ 44(a), GC No. 14).

[104] See, e.g., Ibidem supra note 60, J. Tobin 2012, p. 264 (citing relevant studies).

[105] Ibidem supra note 85, GC No. 5.

courts, by public authorities, in case of conflict with domestic legislation or common practice etc.).[106]

(b) Administrative measures requiring cross-sectoral coordination across and between different levels of government and civil society, in particular children and young people themselves, the development of a comprehensive national strategy based on the framework of the CRC as well as independent and self-monitoring of implementation.[107]

In the meantime, the Guidelines prepared by the CRC Committee to assist States in their reporting process under the CRC are slightly more directed in guiding States to satisfy the requirement of appropriateness. Accordingly, in assessing the appropriate character of measures taken, States are expected to indicate whether they have adopted a comprehensive national strategy for the implementation of the right to health, including efforts to combat diseases particularly among special groups of children at high risk, to address health issues of adolescents.[108] Further, States are required under the Guidelines to specify the effect of the implementation measures for the realization of the right to health by providing data with respect to a number of health indicators.[109]

In light of the above, it must be conceded that States enjoy a margin of discretion as to the selection of the measures they adopt to satisfy their obligation to secure the right to health of children, as they are better aware of their national circumstances than the CRC Committee.[110] However, States are still required to justify whatever measures they adopt as being appropriate under the prevailing circumstances within their jurisdiction. To this aim, analogously to the CESCR, the CRC Committee has endorsed the test of reasonableness for the assessment of the appropriateness of the measures taken on the part of the States for realizing progressively the right to health as well as the criteria listed by the CESCR to this end.[111] In the same broad manner as CESCR, the application of the 'reasonableness

106 Ibid., §§ 18-23.

107 Ibid., §§ 26-27, 28-36 and 46.

108 UN CRC Committee, *General Guidelines regarding the form and the content of Periodic Reports to be submitted by States Parties under Article 44, paragraph 1(b), of the Convention,* UN Doc. CRC/ C/58/Rev.1, 29 November 2005, § 32; latest version of guidelines, UN Doc. CRC/C/58/Rev.2, 25 November 2010, §§ 19(b) and 34.

109 Ibid., UN Doc. CRC/C/58/Rev.2, Annex § F 2.

110 See, e.g., A. Müller, 'Limitations to and Derogations from Economic, Social and Cultural Rights', *Human Rights Law Review* 2009, pp. 557-601, p. 565.

111 UN CRC Committee, Report on the Forty-Sixth Session, UN Doc. CRC/C/46/3, 22 April 2008, ch VII, § 90 (Day of General Discussion on 'Resources for the Rights of the Child

test' is outlined by the CRC Committee with regard to the communications procedure for children under the Optional Protocol III to the CRC.[112] Accordingly, Article 10(4) of the OP III to the CRC on communications provides that 'When examining communications alleging violations of economic, social or cultural rights, the Committee shall consider the reasonableness of the steps taken by the State party in accordance with Article 4 of the Convention. In doing so, the Committee shall bear in mind that the State party may adopt a range of possible policy measures for the implementation of the economic, social and cultural rights in the Convention'.[113] As an analysis of the notion of the 'reasonableness' is to be found in the previous section in relation to the CESCR's approach which has been also adopted by the CRC Committee, it is not necessary to repeat it here.

At the same time it remains clear that the CRC Committee retains final authority to assess the course of State action or inaction, as in the case of the CESCR. This, however, alludes that the CRC Committee will have to articulate and give content to its interpretations of the appropriateness requirement in specific cases by setting concrete targets and giving specific guidelines on the measures that must be taken, when formulating its recommendations to States. In practice, in its CO, the CRC Committee has tended to avoid this discussion. Many of its comments are confined to expressions of concern (repeated calls of concern at times) accompanied with general recommendations which are slightly directed in guiding States. For example, the Committee has often expressed concern at the lack of a comprehensive policy[114] and, therefore, urged States, as found in its CO for Philippines to 'develop and implement comprehensive policies and programmes for improving the health situation of children'.[115]

Responsibility of States', 5 October 2007); Ibidem supra notes 37, 38 and 39 as regards the approach taken by the CESCR.

112 Article 10 § 4 of the OP III to CRC, adopted by the General Assembly on 19 December 2011, entered into force on 14 April 2014, UN Doc. A/RES/66/138, 27 January 2012; Ibidem supra note 95, Spronk 2014, pp. 243-249 for an elaboration of the reasonableness requirement in relation to the right to health of the child (citing relevant studies).

113 Ibid.

114 See, e.g. UN CRC Committee, CO: Lithuania, UN Doc. CRC/C/LTU/CO/3-4, 30 October 2013, § 10; CO: Andorra, UN Doc. CRC/C/AND/CO/2, 30 November 2012, § 14.

115 UN CRC Committee, CO: Philippines, UN Doc. CRC/C/15/Add.259, 21 September 2005, § 59(b); See, also, e.g. UN CRC Committee, CO: Algeria, UN Doc. CRC/C/15/Add.269, 12 October 2005, § 57(a); CO: Bangladesh, UN Doc. CRC/C/15/Add.221, 27 October 2003, § 52(a); CO: Liberia, UN Doc. CRC/C/LBR/CO/2-4, 11 December 2012, § 12; CO: Pakistan, UN Doc. CRC/C/15/Add. 217, 27 October 2003, § 53(a); CO: Guinea-Bissau, UN Doc. CRC/C/15/Add.177, 13 June 2002, § 10.

The Committee has, however, alluded that a national health policy must treat children as a heterogeneous group (e.g., by means of adoption of age-adjusted measures) in its work (i.e., GCs and CO), where it suggested three main classifications as to the definition of children on the basis of their age as well as noted the position of vulnerable children.[116] Thereto, States are required to adopt measures that are targeted and adapted to the diverse and changing health needs due to the different developmental stages of specific groups of children, whose age ranges from early childhood to adolescence, as noted earlier in this chapter. It is on this basis that the CRC Committee has noted that during early childhood States must pay attention to areas such as prenatal and post-natal health care for mothers and infants, immunization, the advantages of breastfeeding, and the encouragement of healthy lifestyle practices, involving nutrition, hygiene and sanitation and in practice has welcomed the adoption of such policies in countries.[117] Further, as regards adolescents the CRC Committee has stressed that the focus of State measures must be on additional health issues, involving reproductive health, substance abuse and mental health.[118] For example, in its CO for particular countries, the CRC Committee has often expressed concern on issues involving teenage pregnancy, information accessibility about sexually transmitted diseases, accessibility of counseling services and prevention methods.[119]

At the same time, besides the development and adoption of age-adjusted measures, the CRC Committee has on many occasions observed that States must further consider and develop targeted health interventions that respond to the special and different needs of several groups of vulnerable children.[120] Particularly,

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116 Ibidem supra note 89, GC No. 4, § 2; Ibidem supra note 86, GC No. 7, §§ 27(a)-(b); Ibidem supra note 85, GC No. 15, § 98; Ibidem supra note 60, J. Tobin 2012, pp. 219-220.

117 Ibidem supra note 86, GC No. 7, §§ 27(a)-(b); The CRC Committee welcomes the adoption of State policies, such as policies for improving early growth and development of children (See, e.g., CO: Bosnia and Herzegovina, UN Doc. CRC/C/BIH/CO/2-4, 29 November 2012, § 6(a); See, e.g. UN CRC Committee, CO: Romania, UN Doc. CRC/C/ROM/CO/4, 30 June 2009, § 65; See for a relevant approach, e.g., WHO Regional Office for Europe, *Investing in children: the European child and adolescent health strategy 2015–2020*, Copenhagen: WHO, September 2014.

118 See, e.g., UN CRC Committee, CO: Burkina Faso, UN Doc. CRC/C/15/Add.193, 9 October 2002, § 467; Ibidem supra note 14, GC No. 14, § 23 for an analogous approach adopted by the CESCR as regards adolescents.

119 See, e.g. UN CRC Committee, CO: South Africa, UN Doc. CRC/C/15/Add.122, 22 February 2000, § 31; CO: Israel, UN Doc. CRC/C/ISR/CO/2-4, 4 July 2013, § 56; CO: Lithuania, UN Doc. CRC/C/LTU/CO/3-4, 30 October 2013, § 42.

120 Ibidem supra note 85, GC No. 5, §§ 29-30; Ibidem supra note 86, GC No. 7, § 24; See,

in its CO for certain countries the CRC Committee has repeatedly expressed concern on children belonging to vulnerable groups, such as indigenous children[121], Roma children[122], asylum-seeking or refugee children[123], and children with mental health problems[124], children living in poverty[125].

All in all, we may conclude that beyond its expressions of concern accompanied with general recommendations and guideposts the work of the CRC Committee reveals no intention of itself to elaborate more fully on what constitutes 'all appropriate measures' (i.e., by way of prescribing in detail the measures required by States under the right to health), just as found earlier in the examination of the work of the CESCR. As such, the Committee's work -relatively abstract at times- represents an incomplete approach on the understanding of the clause 'all appropriate means' and it is questionable whether it offers practical insights on this issue for actually guiding States to achieve this end. Meanwhile, in defence of the CRC Committee's approach, one might suggest that the margin of discretion afforded to States can perhaps provoke a public debate[126] (i.e., a constructive dialogue) between the Committee and States as to the definition of the nature of the appropriate measures required under the right to health, whilst ensuring a context-sensitive interpretation of such measures (i.e., national circumstances and challenges).[127]

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e.g., CO: Republic of Moldova, UN Doc. CRC/C/15/Add.192, 31 October 2002, §§ 27(b) and 50(a); Ibidem supra note 60, J. Tobin 2012, p. 220; For vulnerable population groups of children in Greece, see, Chapters 7 (undocumented migrant children) and 8 (Roma children).

121 See, e.g., UN CRC Committee, CO: Canada, UN Doc CRC/C/15/Add.215, 27 October 2003, § 34.

122 See, e.g., UN CRC Committee, CO: Greece, UN Doc CRC/C/15/Add.170, 2 April 2002, § 56(e); CO: Slovakia, UN Doc. CRC/C/15/Add.140, 23 October 2000, § 35; CO: Bosnia and Herzegovina, UN Doc. CRC/C/15/Add.260, 21 September 2005, § 47; CO: Republic of Moldova, UN Doc. CRC/C/15/Add.192, 31 October 2002, §§ 26, 49.

123 See, e.g., UN CRC Committee, CO: Netherlands, UN Doc. CRC/C/NLD/CO/3, 27 March 2009, § 27; CO: United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/4, 20 October 2008, § 25(b).

124 See, e.g., UN CRC Committee, CO: United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/4, 20 October 2008, § 57.

125 See, e.g., UN CRC Committee, CO: China, UN Doc. CRC/C/CHN/CO/3-4, 29 October 2013, § 63.

126 See, e.g., Ibidem supra note 85, GC No. 5, § 26. Indeed, the CRC Committee has particularly noted that its work entails '*its ongoing dialogue with Governments* and with the United Nations and United Nations-related agencies, NGOs and other competent bodies' [emphasis added].

127 Ibid.; See, e.g., Ibidem supra note 60, J. Tobin 2012, p. 258; Ibidem supra note 11, E. Riedel

(b) '[…] to the maximum extent of their available resources and, where needed, within the framework of international co-operation.*'*

The right to health of children requires States to adopt a series of measures as such listed in the sub-paragraph of Article 24 CRC, dependent however upon the allocation of States' available resources, namely 'to the maximum extent of their available resources.'[128] On this issue, the work of the CRC Committee has generally identified that the term 'resources' involves not only financial resources, but also human, technological, organizational, natural and information resources, whose allocating by the State must be transparent, effectively, efficiently and participatory.[129] Importantly, this approach has been also endorsed by the CESCR, as observed previously (see section 4.2.1).

In practice, the CRC Committee has tended to adopt a rather haphazard approach in its CO as to the actual meaning of this term. Many of its comments are confined to broad calls for action which do not provide any workable solution - guidance to States on this matter. For example, the CRC Committee has urged in its CO particular States 'to ensure that appropriate resources are allocated for the health sector … for improving the health situation of children'[130], 'to ensure appropriate allocation of the financial, human and technical resources'[131], 'to allocate the necessary resources … with a view to guarantee to all children with disabilities, in particular those living in rural areas, access to … health care'[132], 'increase the resources allocated to the health sector, … for improving the health situation of children'[133] and 'take effective measures to allocate the maximum extent of available resources for social services and programmes for children, and

2009, p. 27. Note that the same abstract approach is also adopted by the CESCR if one looks at the CESCR's work on this issue (i.e., see the comment made earlier when examining the work of the CESCR).

128 Article 4(2) CRC reads as follows: '[…] With regard to economic, social and cultural rights, States Parties shall undertake such [appropriate] measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation'.

129 Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, ch VII, §§ 65 & 73-75.

130 UN CRC Committee, CO: Philippines, UN Doc. CRC/C/15/Add.259, 21 September 2005, § 59(b).

131 UN CRC Committee CO: Greece, UN Doc. CRC/C/GRC/CO/2-3, 13 August 2012, § 14.

132 UN CRC Committee CO: Republic of Guinea, UN Doc CRC/C/GIN/CO/2, 30 January 2013, § 64; CO: Guyana, UN Doc. CRC/C/GUY/CO/2-4, 5 February 2013, § 46(c).

133 UN CRC Committee CO: Republic of Guinea, UN Doc CRC/C/GIN/CO/2, 30 January 2013, § 66(a).

that particular attention be paid to the protection of children belonging to vulnerable and marginalized groups'.[134] In addition to the various -broadly phrased- calls for action in relation to the allocation of resources, other comments of the CRC Committee have tended to be limited to expressions of concern without further elaborating on the actual meaning of the term 'the maximum extent of available resources'. For instance, the CRC Committee has on many occasions expressed concern 'at the cuts in social expenditure in the national budget … and at their negative impact on health … welfare areas for children'[135] as well as at the distribution of resources to military expenses to the detriment of expenditure on children' health.[136] In a rather general and abstract sense, the CRC Committee has also suggested States to seek assistance for the realization of the right to health through international co-operation in line with Articles 4(2) and 24 § 4 CRC, which could complement the resources available at the national level.[137] Nonetheless, the Committee has expressed concern with regard to the sustainability of such resources, due to the sole dependence of developing States on foreign aid.[138]

At the same time, beyond broad exhortations and concerns, the Committee has considered the support of families as a part of the term resources by noting in its work 'the importance of systematically supporting parents and families who are among the most important *available resources* for children' [emphasis added].[139] In addition to the support of families, the Committee has identified that States are required to provide sufficient human resources for the purpose of realizing the right to health of children.[140] Put simply, this alludes that a sufficient number of

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134 UN CRC Committee, CO: Costa Rica, UN Doc. CRC/C/15/Add.117, 24 February 2000, § 14.

135 Ibid.; UN CRC Committee, CO: China, UN Doc. CRC/C/CHN/CO/3-4, 29 October 2013, § 13(a) & (b).

136 See, e.g., UN CRC Committee, CO: Sudan, UN Doc. CRC/C/SDN/CO/3-4, 22 October 2010, § 17-18.

137 See, e.g., UN CRC Committee, CO: Guinea-Bissau, UN Doc. CRC/C/15/Add.177, 13 June 2002, § 12; CO: Burkina Faso, UN Doc. CRC/C/BFA/CO/3-4, 9 February 2010, § 17(a) and (f); Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, ch VII, § 65.

138 UN CRC Committee, CO: Guinea-Bissau, UN Doc. CRC/C/15/Add.177, 13 June 2002, § 11.

139 Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, § 66. This requirement is also reflected in the wording of Article 24 § 2 (e) and (f) CRC which stresses that States must provide information and guidance to parents concerning their children's health needs.

140 See, e.g., UN CRC Committee, CO: Burkina Faso, UN Doc. CRC/C/BFA/CO/3-4, 9

adequately trained health personnel, including paediatric and specialized care practitioners, must be available to respond to the health needs of children within a State's jurisdiction. It is on this basis that the Committee has expressed concern about the structural lack of health personnel as well as the on-going 'skills drain', namely the migration of such personnel from developing States to developed States.[141]

Last but not least, the CRC Committee, rather than detail explicitly and in full what constitutes 'the maximum extent of their available resources', has been confined to general recommendations to States to ensure that expenditure on children's right to health, and particularly the most disadvantaged, constitutes a priority in state budgets.[142] This approach has been affirmed in its GC No. 15, where in a general sense States are required to secure the right to health of children 'even in the context of political or economic crisis or emergency situations' by giving priority, albeit without elaborating on the means to achieve this end (i.e., nature and way of allocation of resources).[143] The Committee has, however, hinted at the optimally distribution of existing (even scarce) resources in its preceding general recommendations where it noted the prioritization of health needs of discrete groups of children in State budgets (see also section 4.2.3).

4.2.3. UN SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH

Since 1979, special mechanisms, monitoring specific country situations or themes, such as torture, from a human rights perspective, have been established by the then Commission on Human Rights. This UN human rights body was replaced by the UN Human Rights Council (henceforth: HRC) in June 2006. These special procedures are international mechanisms, focused on the advancement of the

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February 2010, § 55; UN CRC Committee, CO: Hungary, UN Doc. CRC/C/HUN/CO/3-5, 14 October 2014, § 47.

141 See, e.g., UN CRC Committee, CO: South Africa, UN Doc CRC/C/15/Add.122, 22 February 2000, §§ 16 and 29; See other sources, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 60th Sess., Agenda Item 73(b),* UN Doc. A/60/348, 12 September 2005, §§ 27-29.

142 See, e.g. UN CRC Committee: CO: Togo, UN Doc. CRC/C/15/Add.83, 21 October 1997, § 34; CO: Nigeria, UN Doc. CRC/C/15/Add.61, 30 October 1996, § 10; CO: Zambia, UN Doc. CRC/C/15/Add.206, 2 July 2003, § 16; CO: Democratic Republic of Korea, UN Doc. CRC/C/15/Add.239, 1 July 2004, § 18; Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, ch VII, § 71(a).

143 Ibidem supra note 85, GC No. 15, § 74.

enjoyment of human rights with the explicit objective of elucidating the normative framework of these rights; and the scope of State obligations arising from these rights.[144] Until 1998, the UN Special Rapporteurs have primarily focused on the promotion and protection of CP rights (e.g., the prohibition against torture, freedom of religion).[145] However, in 1998 the focus of attention of this UN special procedure shifted to the protection of ESC rights and the same year the first Special Rapporteur on the Right to Education was appointed (i.e., Katarina Tomaševski under the founding UN Res. 1998/33).[146] Then, in 2000 the appointments of two more Special Rapporteurs on the Right to Food and Adequate Housing followed.[147]

In 2002, the UN decided to establish the position of Special Rapporteur on *the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* ('Right to Health'). The mandate of the Special Rapporteur on the Right to Health was originally established by the then UN Commission on Human Rights on 22 April 2002 by the founding UN Resolution 2002/31.[148] On the basis of this UN's decision, Paul Hunt of New Zealand was appointed in the position in August 2002 by the Chairperson of the then UN Commission on Human Rights for a term of three years (founding UN Res. 2002/31), which was renewed until July 2008 (Res. 6/29 & Res. 2005/24).[149] In June 2008 the HRC, which replaced the Commission, appointed Anand Grover of India as Special Rapporteur on the Right to Health (term: August 2008 - June 2014, when Dainius Pūras of Lithuania took over), while all existing mandates of the then UN Commission on Human Rights were transferred to this new body.

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144 See Website of the UN <www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>

145 The mandates of Special Rapporteurs on the Question of Torture and on the Freedom of Religion or Belief were originally established by Res. 1985/33 and 1986/20, respectively.

146 UN Commission on Human Rights, UN Doc. E/CN.4/RES/1998/33, 17 April 1998.

147 The mandates of Special Rapporteurs on the Right to Food and Adequate Housing were originally established by Res. 2000/10 and Res. 2000/9, respectively. It is noteworthy that Special Rapporteurs on the rights essential to social determinants of health, such as education, housing, have made contributions to define respective rights (see, e.g., Report of the Special Rapporteur on the Right to Education, UN Doc. E/CN.4/2004/45, 15 January 2004 and Report of the Special Rapporteur on Adequate Housing as a Component of the Right to an adequate Standard of Living, UN Doc. E/CN.4/2002/59, 1 March 2002).

148 UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 2002/31, UN Doc. E/CN.4/RES/2002/31, 22 April 2002.

149 Ibid.; See, also, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 2005/24, UN Doc. E/CN.4/RES/2005/24, 15 April 2005; Ibidem infra note 151, Res. 6/29.

However, the UN HRC reserved the right to review all mandates in the future in order to 'improve and rationalize' them.[150]

Like other Special Rapporteurs, the Special Rapporteur on the Right to Health is an independent expert, working in his/ her personal capacity, appointed to protect and promote a specific human right, the right to health and does not represent any country. The Special Rapporteur does not receive payment by the UN and can serve a maximum of two terms. The Special Rapporteur on the Right to Health has three main areas of work. In order to fulfil the mandate the Special Rapporteur on the Right to Health submits an annual report both to the UN HRC (former: Commission on Human Rights) and to the UN General Assembly on several health-related issues (thematic reports), undertakes official country and other missions (country reports) maximum two per year and receives individual complaints (reports on 'communications') of alleged violations of the right to health.[151] Moreover, the Special Rapporteur can undertake additional activities in the course of his mandate, such as attending relevant meetings organized by governments, international organizations. Resolutions may also request the Special Rapporteur to examine specific issues. For instance, Grover was requested by Res. 15/22 to examine the realization of the right to health of older persons.[152]

Given the broad range of topics employed by the Special Rapporteur on the Right to Health over the years (2002-2015), this section will limit itself to certain issues by means of which the right to health is to be implemented that are increasingly addressed in the reports of the consecutive Special Rapporteurs on the Right to Health. This refinement can add value to the interpretation of the right to health as regards the nature and scope of state measures and available resources, required for its realization.

As increasingly affirmed by Hunt central to the enjoyment of the right to health is the requirement for States to adopt a comprehensive national health strategy

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150 See, § 6 GA Res.- A/RES60/251- that replaced the Commission with the Human Rights Council; Note that the UN HRC appointed Dainius Pūras from Lithuania as Special Rapporteur on the Right to Health at its twenty-sixth session in June 2014.

151 See, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 2003/28, UN Doc. E/CN.4/RES/2003/28, 22 April 2003; UN Human Rights Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 6/29, UN Doc. HRC/RES/2007/6/29, 14 December 2007.

152 UN Human Rights Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 15/22, UN Doc. A/HRC/RES/15/22, 6 October 2010, § 11.

through the participation of all relevant beneficiaries, including marginalized groups.[153] He has repeatedly declared that the active and informed participation of individuals and communities in health policymaking that affects them is a significant feature of the right to health.[154] A similar attitude is also adopted by Grover and Pūras in their own reports to the General Assembly and the Human Rights Council, respectively.[155] Nevertheless, Hunt has observed that effective participation of all stakeholders is a difficult task for States to perform, in that it requires both time and 'innovative arrangements' which will rely upon existing local and national democratic structures.[156] As a way to promote participation of all stakeholders, Hunt identified human rights impact assessments.[157] Particularly, he has explained that the objective of impact assessments is to inform decision-makers and the likely

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153 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 62nd Sess., Agenda Item 72(b),* UN Doc. A/62/214, 8 August 2007, §§ 24-25; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 7th Sess., Agenda Item 3,* UN Doc. A/HRC/7/11, 31 January 2008, § 89; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 62nd Sess., Agenda Item 10*, UN Doc. E/CN.4/2006/48, 3 March 2006, §§ 7, 25 and 49(c)(i).

154 See, e.g., Ibid.; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 59th Sess., Agenda Item 105 (b).* UN Doc. A/59/422, 8 October 2004, § 24; Ibid., UN Doc. A/62/214, § 84; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 61th Sess., Agenda Item 10*, UN Doc. E/CN.4/2005/51, 11 February 2005, §§ 59-61; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN GA, 63rd Sess., Agenda Item 67(b),* UN Doc. A/63/263, 11 August 2008, § 55 and Annex § 9.

155 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover. UN GA, 67th Sess., Agenda Item 70(b),* UN Doc. A/67/302, 13 August 2012, §§ 4 and 7; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Dainius Pūras, UN HRC, 29th Sess., Agenda Item 3,* UN Doc. A/HRC/29/33, 2 April 2015, §§ 110-111.

156 Ibidem supra note 154, UN Doc. A/59/422, § 25.

157 Ibidem supra note 153, UN Doc. A/62/214, §§ 37, 40-41 and 44; Note that Hunt has identified human rights impact assessment also as a monitoring and accountability mechanism (see, UN Doc. A/58/427, 10 October 2003, § 53(i) and UN Doc. A/59/422, 8 0ctober 2004, § 38).

affected individuals/groups so as to enhance a proposed initiative by minimizing potential negative consequences and increasing positive ones, prior to its finalization and adoption.[158] Nonetheless, several scholars have been critical of the views expressed by Hunt in relation to the notion of participation.[159] For instance, it has been commented that effective participation (i.e., active and informed participation) of *all* stakeholders [emphasis added] is 'simply unworkable' in that it demands both time and resources both of which will invariably be restricted.[160] Meanwhile, in addition to participation, much attention in the reports of the Special Rapporteurs is drawn to the notion of accountability. Hereto, all three consecutive Special Rapporteurs have emphasized the importance of effective accountability mechanisms in relation to the right to health, involving priority-setting process, in several reports since 2002.[161] For instance, Hunt has stressed that accountability is concerned with ensuring*, inter alia*, that the right to health 'is being progressively realized for all, including disadvantaged individuals, communities and populations'.[162]

Another issue that has been consistently looked at in the reports of the respective body is the concept of vulnerability in relation to the enjoyment of the right to health. It is within this context that Hunt has remarked that 'vulnerability and disadvantage are among the reasonable and objective criteria that must be applied when setting priorities'.[163] Herein, Grover has suggested that 'vulnerable groups should not be limited to those specific groups mentioned in General Comment No. 14, but should include any group that is disproportionately affected by a particular ailment or otherwise marginalized on account of its members' political, social or economic exclusion; discrimination and stigmatization suffered by that group; restrictions in law or in practice on giving informed consent or

158 Ibidem supra note 153, UN Doc. A/62/214, § 37.

159 See, e.g., U. Baxi, 'Place of the Human Right to Health and Contemporary Approaches to Global Justice', in: Harrington and Stuttaford (eds.), *Global Health and Human Rights*, London and New York: Routledge 2010, pp. 12-27, p. 18 (citing relevant studies); Ibidem supra note 60, J. Tobin 2012, p. 217.

160 Ibidem supra note 60, J. Tobin 2012, p. 217.

161 See, e.g., UN Doc. A/59/422 (supra note 154), §§ 17, 36-41; UN Doc. A/62/214 (supra note 153), § 27; UN Doc. E/CN.4/2005/51 (supra note 154), §§ 67-75; UN Doc. A/63/263(supra note 154) § 8-18 (citing relevant reports); UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN HRC, 17th Sess., Agenda Item 3*, UN Doc. A/HRC/ 17/43, 16 March 2011, § 49(g); UN Doc A/67/302 (supra note 155), § 7; UN Doc. A/HRC/ 29/33 (supra note 155), §§ 29 and 34.

162 Ibidem supra note 153, UN Doc. A/HRC/7/11, § 101.

163 Ibidem supra note 153, UN Doc. A/62/214, § 26.

exercising full autonomy by members of that group; or the group's inability to enforce rights, gain access to State benefits or enjoy regulatory protection.'[164] Of note, all three consecutive Special Rapporteurs have paid particular attention to several vulnerable groups and their prospects for enjoyment of the right to health, including women, children, members of ethnic minorities and people with a low socio-economic status.[165] For instance, Grover has observed that in terms of fulfilling the right to health, States are required to adopt and implement a national health policy that does not discriminate against non-nationals and address their special health needs.[166] By way of example, he has recommended States to 'abolish discriminatory immigration policies that require mandatory testing for health conditions, such as HIV and pregnancy, which are not based on clearly established scientific evidence and violate the right to health'.[167] He went further by stressing that States should 'delink access to health facilities, goods and services from the legal status of migrant workers and ensure that preventative, curative and emergency health facilities, goods and services are available and accessible to all migrant workers, including irregular migrant workers, in a non-discriminatory manner'.[168]

Aligned with the requirement for special attention to the position of vulnerable

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164 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN GA, 69th Sess., Agenda Item 69 (b),* UN Doc. A/69/299, 11 August 2014, § 28; See, also, UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 4th Sess., Agenda Item 2*, UN Doc. A/HRC/4/28/Add.2, 28 February 2007, § 73.

165 See, e.g., Ibid.; UN Doc. A/HRC/29/33 (supra note 155), §§ 35 and 44; See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10,* UN Doc. E/CN.4/2003/58, 13 February 2003, § 66 (racial and ethnic minorities); UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover. UN GA, 64th Sess., Agenda Item 71(b).* UN Doc. A/64/272, 10 August 2009, pp. 13-23 (children, women, ethnic minorities, indigenous persons, persons with disabilities etc.); UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN GA, 66th Sess., Agenda Item 69 (b),* UN Doc. A/66/254, 3 August 2011, § 31(poor and marginalized women).

166 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN HRC, 23rd Sess., Agenda Item 3,* UN Doc. A/HRC/23/41, 15 May 2013, § 11.

167 Ibid., UN Doc. A/HRC/23/41, § 76(g).

168 Ibid., UN Doc. A/HRC/23/41, § 76(h).

population groups within the context of designing and implementing (a context-sensitive) national health strategy, Hunt has repeatedly emphasized that States have to develop effective and responsive health systems as well as the critical role of health professionals to achieve this end.[169] Illuminating in this respect is his analysis on right-to-health features of a health system, where he underlines that 'at the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Without such a health system, the right to the highest attainable standard of health can never be realized' (see section 3.7).[170] In this analysis, Hunt also asserts that a health system is connected to the social determinants of health, due to its potential 'to secure sustainable development, poverty reduction, economic prosperity, improved health for individuals and populations, as well as the right to the highest attainable standard of health'.[171] At the same time it must be accepted that the development of such health system largely depends upon adequately trained health professionals whose overall task is to improve individual and public health, and who represent the human resources required by States as observed earlier.[172]

On the issue of the available resources and their allocation, Hunt has underpinned -albeit at a relatively general level- that due to the availability of resources one of the pressing challenges for the realization of the right to health is its effective integration

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169 See, e.g., UN Doc. A/HRC/7/11 (supra note 153), § 15; UN Doc. E/CN.4/2006/48 (supra note 153), § 4.

170 Ibidem supra note 153, UN Doc. A/HRC/7/11, § 15; Note that the preamble of the WHO Constitution provides that 'Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures' (Constitution of the World Health Organization, adopted by the International Conference held in New York 22 July 1946, entered into force 7 April 1948, 14 UNTS 185).

171 Ibidem supra note 153, UN Doc. A/HRC/7/11, § 16; Note that the CSDH has also argued in its final report that a health system is an important determinant of health, which interacts with other social determinants, such as education and occupation in terms of access to health care. (CSDH, *Closing the gap in a generation: Health equity through action on social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva: World Health Organization 2008, pp. 8, 94).

172 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN GA, 60th Sess., Agenda Item 73(b),* UN Doc. A/60/348, 12 September 2005, §§ 8-17; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 4th Sess., Agenda Item 2,* UN Doc. A/HRC/4/28, 17 January 2007, § 41.

in national and international health-related policy making.[173] In fact, Grover has declared that the clause of 'available resources' has not been explicitly defined within the right to health framework or GC No. 3 of the CESCR.[174] Nonetheless, this incomplete perspective on available resources may be problematic as this term could be interpreted as a *carte blanche* by States and applied in practice in diverse ways -i.e., States could do as they please-.[175] It was on this basis that Grover argued that this clause 'could mean a State's entire gross domestic product or a specified percentage thereof, or it could be limited to the amount allocated to the State's health budget or limited to the amounts allocated to a particular health concern'.[176] In spite of this conceptual obscurity, he opined that the term 'available resources' tends to refer to 'the totality of a State's 'real' resources, involving informational, technical, organizational, human, natural and administrative resources, above and beyond budgetary allocations'.[177] In terms of reviewing the amount of available resources provided by States, Grover highlighted also the need for States to manage the existing budget efficiently by focusing on the reasonableness of the policymaking; on the impact upon vulnerable groups; on the transparency and participatory nature of such process; and to generate additional resources, which may include, for instance, changes to the State's taxation policy, smart incurrence of debt or international funding under the state obligation to internationally co-operate (see section 4.4).[178]

In the meantime it must be conceded that the realization of the right to health does not rely solely on the accumulation and increase of a State's resources, but also on the way of allocating existing (even limited) resources in a State's budget. In other words, States should make optimally use of such resources, by giving first priority to their populations' most basic health needs, including paying attention to vulnerable groups, such as undocumented migrants, minorities (Roma), regardless of resource constraints owed to external circumstances (e.g., an influx of refugees, an outbreak of an epidemic or an economic recession etc.).[179] As such,

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173 Ibidem supra note 153, UN Doc. A/62/214, §§ 11-12.

174 Ibidem supra note 164, UN Doc. A/69/299, § 21.

175 See, e.g., supra note 11, E. Riedel 2009, p. 30.

176 Ibidem supra note 164, UN Doc. A/69/299, § 21.

177 Ibid.

178 Ibidem supra note 164, UN Doc. A/69/299, §§ 21 & 75(e); UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover. UN GA, 67th Sess., Agenda Item 70(b),* UN Doc. A/67/302, 13 August 2012, §§ 7, 15 and 22.

179 Ibidem supra note 165, UN Doc. E/CN.4/2003/58, § 27; Ibidem supra note 164, UN Doc. A/69/299, § 29; See, generally, A. Chapman & S. Russell, *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Belgium: Intersentia 2002.

the amount of adequate funds to be available for health should be informed by the core obligations of the right to health, which establish a 'funding baseline'.[180] Additionally, as to the way in which existing resources should be distributed within a State, Grover has recommended that the realization of the right to health should not be given priority over other competing demands on the State, as he has indicated 'available resources should imply the maximum amount of resources that can be allocated to a specific health objective without compromising other essential services', such as spending on education, social security, defence.[181] He went further by explaining that a State's decreasing budgetary allocation for its right to health obligations vis-à-vis its increasing GDP or increasing allocation to areas other than those relating to the right to health may be evidence that the State has chosen to allocate insufficient expenditure or misallocate available resources to fulfil the right to health which may amount to a violation of this right.[182] As such, Grover acknowledged that it is the burden of the State to demonstrate that the amount of its available resources does not 'permit' the fulfillment of its right to health obligations.[183] This could be achieved through the provision by the State information on the calculation of its available resources, budget allocations and state efforts to increase the available resources.[184]

From the perspective of the preceding analysis the following observations can be discerned. First, the views expressed by the consecutive Special Rapporteurs on the Right to Health in their reports are more informative in character rather than determinative as to the measures required by States. It seems that these reports endeavor to play a role in the development of the right to health primarily at a policy level by making it more tangible and operational (e.g. report on mental disability), before violations occur. It was on this basis that some scholars have been critical of the work of the Special Rapporteur. Baxi -legal scholar and being perhaps the most striking example- opined that the Special Rapporteur focuses more on policy and planning measures (i.e. policy approach) and less on legislative measures, involving the role of legislation and litigation through courts in the realization of the right to health (i.e. judicial approach - legal enforcement of the

180 Ibidem supra note 155, UN Doc A/67/302, § 9.

181 Ibidem supra note 164, UN Doc. A/69/299, § 22; Ibidem supra note 155, UN Doc. A/67/302, § 7.

182 Ibidem supra note 164, UN Doc A/69/299, § 23; Ibidem supra note 155, UN Doc A/67/302, § 6.

183 Ibidem supra note 164, UN Doc A/69/299, § 23.

184 Ibidem supra note 164, UN Doc A/69/299, § 23.

right).[185] Second, it was identified that the work of this monitoring body not only affirms the authoritative approach adopted by the CESCR in GC No. 14 (see section 3.5), but also expands the notion of certain elements of the right to health, such as the development of accountability and participation mechanisms, and looks at them in relation to specific population groups. Third, it is repeatedly indicated in the reports of this body that the adoption of a national health strategy by a State must be both comprehensive and targeted to the diverse health needs of various population groups, especially of vulnerable groups, within a State's jurisdiction if it is to be appropriate. Several groups of people have been identified for being vulnerable to violations of their right to health. As such, measures required by States have to consider the diverse aspects of all existing vulnerabilities. Fourth, the position advanced by Grover reflects a comprehensive understanding as to the meaning of the term available resources and their calculation. It was generally submitted that whatever measures adopted by a State for the purpose of realizing the right to health, these remain subject to the resources available in a State and in the case of resource constraints to the way of accumulating and allocating them on the part of the State. The first step, though, towards this aim is the calculation of the amount of the resources to be available for health within a State. Thereto, it was identified that the least/minimum amount of such resources should be informed by the core obligations of the right to health which constitute a 'funding baseline'.

All in all, it can be observed that the work of the consecutive Special Rapporteurs places an explicit emphasis on the way/process by which States should fulfil their right to health obligations and its outcomes and is less focused on the specification of principal health measures required by States. At the same time, one can argue that such an approach -albeit it has received criticism by scholars- which was also evident in the work of both the CESCR and the CRC Committee, as elaborated previously, tends to provide a common ground of understanding as to the nature of measures required by States under the right to health. Nonetheless, one may agree with a view that the role of legislative measures, litigation through courts and tribunals, which points out, *inter alia*, the justiciability of the right to health, require more considered attention in that their application is equally important to the realization of the right to health (see below section).

[185] Ibidem supra note 159, U. Baxi 2010, p. 14; As regards to the policy approach of the respective Rapporteur see, e.g., UN Doc A/HRC/29/33 (supra note 155), §§ 37-38 and 120.

4.3. EXPLORING THE JUSTICIABILITY OF THE RIGHT TO HEALTH: A FOCUS ON EUROPE

Unlike civil and political rights, the justiciability of economic, social and cultural rights is subjected to a continuous debate since the genesis of such rights.[186] Generally speaking, there are human rights bodies that argue in favor of the justiciability of ESC rights, while at the same time there are scholars who argue otherwise.[187] The CESCR in its GC No. 9 has generally acknowledged that States in terms of their obligation to give effect to the rights recognized in ICESCR must, *inter alia*, provide appropriate means of redress or remedies and appropriate means of ensuring governmental accountability.[188] Further, the Committee has recognized that 'there is no Covenant right which could not, in the great majority of systems, be considered as to possess at least some justiciable dimensions'.[189] Likewise, the former UN Special Rapporteur of the Sub-Commission on the Promotion and Protection of Human Rights on the realization of ESC rights, Türk explicitly expressed an argument for the justiciability of ESC rights. In particular, he stated that 'States should establish, whenever possible, appropriate judicial or administrative review mechanisms concerning economic, social and cultural rights. The identification of core obligations of States regarding these rights should facilitate justiciability of those economic, social and cultural rights which cannot, as yet, be considered justiciable in all States'.[190]

Importantly, judicial enforcement of the right to health is essential for people

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[186] J. Sellin, 'Justiciability of the Right to Health - Access to Medicines. The South African and Indian Experience', *Erasmus Law Review* 2009 Volume 2 Issue 4, pp. 445-464, p. 451; See, generally, F. Coomans, 'Some Introductory Remarks on the Justiciability of Economic and Social Rights in a Comparative Constitutional Context' in: F. Coomans (ed.), *Justiciability of Economic and Social Rights: Experiences from Domestic Systems*, Antwerp/Oxford: Intersentia 2006, pp. 1-16; The term 'justiciability' is used within the context on whether an alleged violation of ESC rights can be reviewed by a judicial or quasi-judicial body (see F. Coomans 2006, p. 4).

[187] Ibid.; See, e.g., arguments for and against the justiciability on the right to equal access to health care, M. San Giorgi, *The Human Right to Equal Access to Health Care*, Cambridge/ Antwerp/ Portland: Intersentia 2012.

[188] Ibidem supra note 32, GC No. 9, §§ 1-2.

[189] Ibidem supra note 32, GC No. 9, § 10; See also, concerning the right to health: UN CESCR, GC No. 14 (supra note 14), § 1.

[190] UN, *The Realization of Economic, Social and Cultural Rights: Report of the Special Rapporteur, Danilo Türk, UN ESCOR, Commission on Human Rights, 44th Sess., Agenda Item 8,* UN Doc. E/CN.4/Sub.2/1992/16, 3 July 1992, § 224.

who are victims of a violation of their right to health and seek for protection.[191] As such, the CESCR has established in GC No. 14 that along with the obligation to adopt legislative and policy measures, States are under the obligation to provide effective remedies in order to ensure the effective enjoyment of the right to health by all persons within their jurisdiction.[192] In addition, the CESCR has elaborated that National Ombudsmen, human rights commissions, consumer forums, patients' rights associations and similar institutions must address violations of this right.[193] Interestingly, a similar position has been endorsed by the CRC Committee in its GC No. 15.[194] From the perspective of strengthening the justiciability of the right to health, the CESCR has also recommended the incorporation in the domestic legal order of international instruments that recognize the right to health.[195]

In the meantime, it is arguable that the right to health, as part of the ESC rights is hardly given the same degree of importance in a court of law or a quasi-judicial procedure as happens with CP rights.[196] In academic literature, Scheinin, for example, points out that some authors express the view that ESC rights lack 'justiciability' because their nature prevents them from being '… invoked in courts of law and applied by judges', while others base their objection to justiciability on the largely 'political', not legal character of treaty obligations.[197] As such, it is noteworthy that

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191 Ibidem supra note 14, GC No. 14, § 59. Accordingly, the CESCR has stated that 'Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both the national and international level. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition'.

192 Ibid.

193 Ibidem supra note 14, GC No. 14, § 59.

194 Ibidem supra note 85, GC No. 15, §§ 119-120.

195 Ibidem supra note 14, GC No. 14, § 60; See, also, UN CESCR, General Comment No. 2: *International Technical Assistance Measures (art.22)*, 2 February 1990, E/1990/23, § 9; UN CRC Committee, General Comment No. 2 *(2002) on the role of independent national human rights institutions in the promotion and protection of the rights of the child*, *Official Records of the General Assembly, Fifty-ninth Session, Supplement No. 41* (A/59/41), annex VIII.

196 See, Article 2 § 1 ICESCR, where 3 clauses regulate the realization of ESC rights, such as the right to health, unlike CP rights (Article 2 ICCPR). These include the obligation 'to take steps', the obligation of progressive realization and the realization to the maximum of the available resources; See, e.g., arguments for the justiciability on the right to equal access to health care, M. San Giorgi 2012 (supra note 187).

197 M. Scheinin, 'Economic and Social Rights as Legal Rights' in: A. Eide, C. Krause & A. Rosas (eds.) *Economic, Social and Cultural Rights: A Textbook*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 2001, pp. 29-54, p. 29.

the legal nature of the right to health is partly due to its connection to other human rights (see section 2.5), as it is often dealt with by adjudicatory bodies *via* civil and political rights. Such a position has been defended by academics. In an elaborate analysis of national and international jurisprudence, Hendriks notes that the right to health can be most often invoked before a court either by relying on a classical human right such as the right to life, or by claiming that the State has violated the principle of non-discrimination. Nevertheless, he concludes that courts or quasi-judicial bodies explicitly acknowledge that States are required to ensure a minimum level of health protection, (equal access to) essential health care and satisfaction of basic human needs.[198]

Over the last decades several developments have taken place at the international and regional level that enforced the justiciability of ESC rights, including the right to health.[199] As such, this section will elaborate on such developments through focusing on Europe, namely on the work of a quasi-judicial body, the European Committee of Social Rights (ECSR), the monitoring body of the (Revised) ESC.[200] In particular, at the CoE level, under the Additional Protocol to ESC, which provides a system of collective complaints, social partners and non-governmental organizations, not individuals, are entitled to lodge complaints of violations of the Charter with the ECSR.[201] In case of admissible complaints, the Committee examines them and then its decision, laid down in a report, is forwarded to the Committee of Ministers. The Committee of Ministers may then, based on this report, adopt a resolution recommending the State to take action to meet its obligations under the Charter.[202] Since 1998, within the framework of collective complaints procedure 118 complaints have been filed before the ECSR, of which around a third has addressed various health-related issues, varying from the consequences of industrial activities on health and the protection of the occupational health of workers to access to healthcare for undocumented migrants, Roma, and sexual and reproductive health education.[203] Subsequently, this collective complaints procedure in relation to the

198 A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, Volume 5, pp. 389-408, pp. 402-403.

199 Ibidem supra note 186, F. Coomans 2006, pp. 1-16, p. 2; Note that at the international level the entry into force of the OP to ICESCR on 5 May 2013 and the OP to CRC on a communications procedure on 14 April 2014 took place.

200 Article 25 (Revised) ESC.

201 The AP ESC provided a system of collective complaints, adopted 9 November 1995 (entered into force in July 1998), CETS 158; See, Articles 1-2 AP ESC.

202 Article 9(1) AP ESC.

203 Up until June 2015. See collective complaints list and state of procedure established by the

way of interpretation of the right to health is set out through an exemplary analysis of three cases, serving as a representative illustration thereof.

Accordingly, in 2004 the ECSR found that 'legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter'.[204] The Committee further stressed that health care is a prerequisite for the preservation of human dignity, which is a fundamental value in European human rights law.[205] Hence, within the context of rights and state obligations, this means that people unlawfully present in a State shall not be denied all entitlement to medical assistance and that access to health care shall not be dependent on lawful residency within the respective State.[206] However, the ECSR clarified that the reforms of the State medical assistance (Aide Médicale de l'Etat) and the Universal sickness cover (Couverture maladie universelle), namely the provision to meet certain costs of health care for an uninterrupted period of more than three months as well as treatment for emergencies and life threatening conditions can be considered sufficient to meet the criteria of Article 13 (Revised) ESC.[207] At the same time, the ECSR pointedly noted that 'the concept of emergencies and life threatening conditions is not sufficiently precise' and, thereby, in practice there are difficulties in the implementation of such provisions concerning access to medical care for undocumented migrants.[208] Nevertheless, the ECSR found that French legislation

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Committee, at: http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp; See, e.g., Complaint No. 22/2003, *Confédération générale du travail (CGT) v. France*, Complaint No. 30/2005 *Maragopoulos Foundation for Human Rights (MFHR) v. Greece*, Complaint No. 19/2003 *World Organization Against Torture (OMCT) v. Italy* and Complaint No. 45/2007, *INTERIGHTS v. Croatia*, Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 69/2011, *Defence for Children International (DCI) v. Belgium*, Complaint No. 47/2008, *Defence for Children International (DCI) v. The Netherlands*, Complaint No. 46/2007, *European Roma Rights Centre (ERRC) v. Bulgaria*.

204 ECSR, *International Federation of Human Rights (FIDH) v. France*, Complaint No. 14/2003, 8 September 2004, § 32.

205 Ibid., § 31.

206 Ibid., § 32.

207 Ibid., §§ 33-34.

208 Ibid., § 34; See, also, Council of Europe, Report of the Ad hoc Working Group on Irregular Migrants (MG-AD), rapporteur: Ryszard Cholewinski, 17-18 December 2003, Doc MG-AD (2003), Strasbourg 12 March 2004, p. 15. It is argued that lack of agreement persists as to what emergency medical care encompasses. For instance, Belgium and Netherlands adopt a broad definition of this term, while Germany a narrower one.

reforms did not violate Article 13 of the Charter as undocumented migrants were not deprived of all entitlement to medical assistance. Meanwhile, the ECSR ruled that other standards apply to undocumented migrant children under Article 17 Revised ESC which protects, in a general manner, the right of children and young persons, including unaccompanied minors, to care and assistance and that French legislation reforms violated this entitlement.[209] (see also chapter 7)

In 2008, the ECSR found that the Bulgarian health insurance legislation discriminated against the most vulnerable groups, including the Roma community, due to insufficient measures to ensure health care for these groups.[210] In particular, the Committee stated that under Article 13 § 1 (Revised) ESC vulnerable people without resources in the event of sickness are entitled to free emergency, hospital, primary and specialized outpatient medical care or coverage of expenses for such types of care.[211] Further, the Committee stressed that Article 11 (Revised) ESC 'imposes a range of positive obligations to ensure an effective exercise of the right to health' and it 'assesses compliance with this provision paying particular attention to the situation of disadvantaged and vulnerable groups'.[212] In this regard, the Committee explicitly underscored health inequalities with regard to the Roma in Bulgaria. The Committee stated that Bulgaria had failed to 'take reasonable steps to address the specific problems faced by Roma communities stemming from their unhealthy living conditions and difficult access to health services'.[213] The ECSR concluded that the legislation (Health Insurance Act) violated Article 11 §§ 1, 2 and 3 (right to health) in conjunction with Article E (non-discrimination) of the Charter as well as Article 13 § 1 (right to social and medical assistance) of the Charter.[214]

In 2013, the ECSR found that Greece had violated the ESC by not responding adequately to the serious environmental pollution and the health hazards in the area of the River Asopos and near the industrial region of Oinofyta caused by liquid industrial waste.[215] Particularly, the Committee noted that 'Under Article 11 of the Charter, everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable … and that in order

[209] Ibid., §§ 36-37.
[210] ECSR, *ERRC v. Bulgaria*, Complaint No. 46/2007, 3 December 2008.
[211] Ibid., §§ 43-44.
[212] Ibid., § 45.
[213] Ibid., § 49.
[214] Ibid., §§ 44 and 51.
[215] ECSR, *International Federation for Human Rights (FIDH) v. Greece,* Complaint No. 72/2011, 23 January 2013.

to fulfill their obligations, national authorities must take specific steps'.[216] In this regard, the Committee stressed that 'in view of the threats of damage to human health of the local inhabitants, according to Article 11 §§ 1 and 3, appropriate measures aimed at removing and preventing all causes of ill-health and diseases in the region of Oinofyta should have been implemented by the Greek authorities'.[217] As such, the Committee ruled that 'these deficiencies constitute a violation of Article 11§§1 and 3 of the Charter'.[218] In addition, the Committee found that 'the Greek authorities did not take appropriate measures to provide advisory and educational facilities for the promotion of health in the present case' thus finding a violation of Article 11 § 2 of the Charter.[219]

The preceding non-exhaustive analysis of the ECSR decisions, without, though, being strictly legally binding for the respective States, invites three observations. First, the ECSR in some decisions interprets the right to health within the context of either the right to health care (Article 11, access to health care) or the underlying determinants of health (Article 11, e.g., access to uncontaminated water, food safety, reproductive and environmental health).[220] Second, some decisions rely on other health-related rights (e.g. Article 13 - the right to social and medical assistance, Article 17 -the right of children and young persons to social, legal and economic protection) where interpreted by the Committee to protect health.[221] Third, some decisions build upon both the right to health (Article 11) and other health-related rights (e.g. Article 13, Article E on non-discrimination).[222] Thereto, one may argue that the aforementioned ECSR decisions can have significant added value not only in bridging the gap between the various contentious arguments with respect to the justiciability of the ESC rights (e.g., the right to health), but also in shaping future decisions of courts and/or quasi-judicial bodies concerning ESC rights.

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216 Ibid., § 146.

217 Ibid., § 149.

218 Ibid., § 154.

219 Ibid., §§ 159-160.

220 See also, e.g., *FIDH v. Greece,* Complaint No. 72/2011, 23 January 2013; *Maragopoulos Foundation for Human Rights (MFHR) v. Greece*, Complaint No. 30/2005, 6 February 2007; *INTERIGHTS v. Croatia*, Complaint No. 45/2007, 30 March 2009.

221 See also, e.g., *FIDH v. France*, Complaint No. 14/2003; *European Roma Rights Center (ERRC) v. Bulgaria*, Complaint No. 48/2008.

222 See also, e.g., *ERRC v. Bulgaria*, Complaint No. 46/2007 *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012; *Medecins du Monde-International v. France*, Complaint No. 67/2011.

4.4. INTERNATIONAL CO-OPERATION

Given that our world becomes highly interconnected (e.g., see international outbreaks, such as the outbreaks of swine flu in 2009, the Ebola epidemic in 2014, and the Zika virus in 2015), efforts to protect health must take into account the potential implications of international co-operation on the realization process of the right to health, an interdependent right (see section 2.5).[223] It is within this context that WHO pointedly notes that 'health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats'.[224] As such, WHO identifies the need for internationally shared responsibility for the protection of health as well as the international existence and spread of threats against the health of all people, mainly posed by infectious diseases, such as the Ebola epidemic (see section 2.2.3).[225] Such a position is well supported when looking at the 2005 International Health Regulations adopted by WHO, which expressly refer to human rights as well as concede the significance of human rights protection in case of health emergencies of international concern.[226]

Within the context of human rights law, Article 2 § 1 ICESCR obliges States to 'take steps, individually and through international assistance and cooperation, especially economic and technical' to progressively realize all economic and social rights including the right to health.[227] Likewise, Article 4 CRC affirms this broad state obligation and provides that States must take all appropriate measures to realize the rights, including the right to health, and 'where needed, within the framework of international co-operation'.[228] At the same time, in relation to the right to health of all children Article 24 § 4 CRC explicitly requires of States to promote and encourage international co-operation with a view to achieving

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223 Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna on 25 June 1993, Part I, § 5; Ibidem supra note 14, GC No. 14, §§ 1, 3 and 40; WHO, International Health Regulations 2005- 2nd ed, Geneva: World Health Organization 2008.

224 See, World Health Organization Website 2016. <http://www.who.int/workforcealliance/members_partners/member_list/who/en>.

225 Ibidem supra note 223, WHO, International Health Regulations 2005, p. 4, § 6(2) & Annex 2; See, e.g., L.O. Gostin, 'Ebola: towards an International Health Systems Fund', *The Lancet* 2014, Volume 384, No 9951, pp. e49–e51.

226 Ibidem supra note 223, WHO, International Health Regulations 2005; See also section 2.2.3.

227 Ibidem supra note 20; See, also, UN CESCR, GC No. 3 (supra note 30), § 14. The CESCR has stressed that 'It is particularly incumbent upon those States which are in a position to assist others in this regard'.

228 Ibidem supra note 82, CRC 1990.

progressively the full realization of this right, with taking particular account of the needs of developing countries (see section 2.2.2).

Added to the respective provisions of human rights law, human rights bodies also consider international co-operation as part of the state obligations for realizing the right to health. For instance, Hunt opined that 'in addition to obligations at the domestic level developed States have a responsibility to provide international assistance and cooperation to ensure the realization of economic, social and cultural rights in low-income countries. This responsibility arises from recent conferences, including the Millennium Summit, as well as provisions of international human rights law'.[229] Nevertheless, he pointedly observed that the parameters of international co-operation are not yet fully drawn.[230] Indeed, an explicit and detailed definition of the duties of international co-operation -by way of concrete measures- is absent in the wording of the respective provisions in both ICESCR and CRC, as quoted previously.[231]

It was on this basis that human rights bodies attempted to inform the meaning and scope of this general state obligation in a way to delineate its ensuing state obligations involving particular areas of extraterritorial co-operation in realizing the right to health. In its authoritative source, GC No. 14 the CESCR has made a number of observations concerning this general State obligation, albeit at a somewhat high level of abstraction as to the measures required by States. By making a partial reference to the terminology of the tripartite typology of States' obligations (see section 3.3) the Committee attempted in a relatively haphazard fashion to elucidate the nature of the ensuing state obligations in this field. In a general sense, the Committee establishes that the State obligation for international co-operation involves the duties to respect the enjoyment of the right to health in other countries, to prevent third parties from violating this right in other countries (i.e. to protect) as well as to facilitate (i.e. a sub-category of the duty to fulfil) access to essential health facilities, goods and services in other countries, wherever possible, and provide (i.e. a sub-category of the duty to fulfil) the necessary aid when required.[232]

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[229] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur*, *Paul Hunt. UN ESCOR, Commission on Human Rights, 60th Sess., Agenda Item 10*, UN Doc. E/CN.4/2004/49, 16 February 2004, § 45; Ibidem supra note 165, UN Doc. E/CN.4/2003/58, § 28.

[230] Ibidem supra note 172, UN Doc. A/60/348, § 60.

[231] See, e.g., E. Riedel 2009 (supra note 11), p. 30.

[232] Ibidem supra note 14, GC No. 14, § 39; Ibidem supra note 85, GC No. 15, § 86; See section 3.3 on the 'tripartite typology'(respect, protect and fulfil) of state obligations; See, e.g., as regards other ESC rights, UN CESCR, *General Comment No. 12: The right to food*, UN

This means that the level of the duty to respect would require States 'refrain *at all times* from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as instruments of political and economic pressure' [emphasis added].[233] Similarly, at a relatively abstract level Hunt affirms in his report to the General Assembly that 'international assistance and cooperation require that all those in a position to assist should, first refrain from acts that make it more difficult for the poor to realize their right to health'.[234] Nevertheless, in literature, Tobin argues that such recommendations may be problematic to the extent that they allude to an absolute prohibition on sanctions and similar measures.[235] Here, we should keep in mind that such general statements, even though phrased in absolute terms, are probably to be qualified in practice when interpreted and applied by States.

In addition to the State abstention, States should ensure that the right to health is given due attention in international agreements and that these agreements do not adversely impact upon the right to health by taking steps.[236] At a rather general level, the Committee has argued that such an obligation extends to States' actions, as members of international organizations, such as the IMF, World Bank and WTO, namely in influencing lending policies, credit agreements and international measures of these institutions towards protecting the right to health.[237] Such a broad approach is also found in the work of Hunt and Grover who both generally encourage States to ensure that international agreements or policies do not adversely impact upon the right to health and that their representatives in international organizations accord primacy to the right to health as well as to the obligation of international

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Doc. E/C.12/1995/5, 12 May 1999, § 36; UN CESCR, *General Comment No. 15: The right to water*, UN Doc. E/C.12/2002/11, 20 January 2003, §§ 31, 33 and 34.

233 Ibidem supra note 14, GC No. 14, § 41; See, e.g., as regards other ESC rights, UN CESCR, GC No. 12 (supra note 232), § 37; UN CESCR, GC No. 15 (supra note 232), § 32.

234 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN GA, 59th Sess., Agenda Item 105 (b),* UN Doc A/59/422, 8 October 2004, § 33.

235 Ibidem supra note 60, J. Tobin 2012, p. 333.

236 Ibidem supra note 14, GC No. 14, § 39; See, e.g., as regards other ESC rights, UN CESCR, GC No. 12 (supra note 232), § 36; UN CESCR, General Comment No. 13: The right to education, UN Doc. E/C.12/1999/10, 8 December 1999, § 56; UN CESCR, GC No. 15 (supra note 232), § 35.

237 Ibidem supra note 14, GC No. 14, § 39; See, e.g., as regards other ESC rights, UN CESCR, GC No. 13 (supra note 236), § 56; UN CESCR, GC No. 15 (supra note 232), § 36.

assistance and co-operation in all policy making matters.[238] The preceding general statements of the human rights bodies represent an incomplete and unbalanced approach on the respective state obligation in that neither body explains in full as to how a State will ensure that the right to health is to be given due attention in international agreements.[239] As such, one can argue that the human rights bodies have tended to avoid opening this discussion in preference for rather broadly-based recommendations.

Similarly, at a rather abstract level the CESCR has also stressed that States have a joint and individual responsibility to provide disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons.[240] This position has been endorsed by the CRC Committee in its non-binding authoritative source, GC No. 15, where the Committee also urges States to allocate 0.7% of gross national income to international development assistance.[241] Nonetheless, it is noteworthy that at least, the preceding exhortation of the CRC Committee is to a certain extent more directed in guiding States as to the way of satisfying their respective obligation.

Last but not least, it must be conceded that the nature of the State obligation for international co-operation is not absolute as the CESCR has stressed that this obligation will depend on each State's capacity (i.e., availability of a State's resources).[242] Thereto, such phrasing gives room for more flexible interpretation and weak implementation of this international State obligation. All in all, the preceding analysis reveals that the precise nature of the State obligation for international co-operation is yet to be elucidated in detail by human rights bodies, namely by way of concrete measures required by States, since so far there is no clear and detailed textual basis for the imposition of such an obligation.

In the meantime, a crucial question is left open as to how the right to health can be realized in a world which is characterized by a persistent shortage of funds followed by a curtailment of health expenditure, economic recession, rising costs, a problem of health sector corruption and a spread of free market principles based

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238 Ibidem supra note 165, UN Doc. E/CN.4/2003/58, § 28; Ibidem supra note 172, UN Doc. A/60/348, § 63; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN HRC, 26th Sess., Agenda Item 3,* UN Doc A/HRC/26/31, 1 April 2014, § 56 and 68(a).

239 Ibidem supra note 60, J. Tobin 2012, see for a similar argument, p. 334.

240 Ibidem supra note 14, GC No. 14, § 40; See, e.g., as regards other ESC rights, UN CESCR, GC No. 12 (supra note 232), § 38; UN CESCR, GC No. 15 (supra note 232), § 34.

241 Ibidem supra note 85, GC No. 15, §§ 88-89.

242 Ibidem supra note 14, GC No. 14, §§ 39-40 and 45.

on privatization of health and other services in both developing and developed -middle income- countries (see Part II).[243] Hence, the prospects for realizing ESC rights, like the right to health, under such conditions may not be as promising as some have believed. It becomes obvious that the realization of the right to health in such a world can be achieved through the change of inadequacies of national and international policies and by setting concrete priorities and targets (see section 4.2).[244]

Despite the existing inadequacies, several policy steps of importance have been made towards the advancement of international co-operation. For instance, States that participated in the World Summit for Social Development endorsed their commitment to eradicate poverty in the world related to health 'through decisive national action and international cooperation, as an ethical, social, political and economic imperative of human kind'.[245] Another perhaps illustrative policy step thereof was the signing of the Oslo Ministerial Declaration by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, on 20 March 2007.[246] This initiative of the seven Ministers of Foreign Affairs, though non-binding, aimed at increasing shared awareness of the value of health as well as of a need for international co-operation towards the protection and advancement of people's health and well-being, through the existence of shared responsibility. Meanwhile, the signatories by means of an Agenda for Action in the field of public health pointed out that health must become a first priority in foreign policy and decisions at the international level and a key element in strategies for development and for fighting poverty, in order to reach the MDGs.[247] Furthermore, the European Commission, in terms of the treaty obligation to protect human health (new Article 168 TFEU, former Article 152 EC Treaty) adopted a health strategy, which encompassed a section on global health (i.e., principle 4:

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243 For an elaboration upon the privatization and corruption within a health care context, see, section 3.7 as well as sections 6.4 - 6.5, where these concepts, including the curtailment of health expenditure, are illustrated and examined by way of a country case study.

244 See, e.g., UN CESCR, GC No. 14 (supra note 14), § 40. It is stressed that 'given that some diseases are easily transmissible beyond the frontiers of a State, there is a collective responsibility on the international community to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard'.

245 UN, *Report of the World Summit for Social Development*, A/CONF.166/9, 19 April 1995, commitment 2, p. 13.; See also section 2.2.3.

246 Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, 'Oslo Ministerial Declaration - Global Health: A pressing foreign policy issue of our time', *The Lancet* 2007, 369 (9750), pp. 1373-1378.

247 Ibid.

'strengthening the EU's voice in global health).[248] Its position represents a relatively balanced perspective on the promotion of co-operation on health-related issues with international organizations and countries. Its health strategy has a particular focus on the enhancement of the safety and security of the EU's citizens and on their protection against health threats by way of setting three strategic objectives to be achieved by the EU Member States.[249]

However, such promotion is still in its infancy. Under the current international economic situation, the expectation that States, through international co-operation, will ensure the realization of the right to health seems unrealistic. There is a limited transnational solidarity to promote the health of all people, given the fact that the development of a common policy may deal with the serious problems and imbalances in health expenditure created by the influence of every country's economic competence ability. For instance, pursuant to World Bank statistics in 2012 the total expenditure on health in Guinea, which was mostly affected by the recent outbreak of the Ebola epidemic (2014), was estimated only at 6.3% of GDP, compared to 9.3% of GDP in Greece and the more impressive 17.9% of GDP in the United States of America (USA).[250] Therefore, the pursuit of the realization of the right to health through international co-operation may conflict with resource constraints (a State's incapacity). The on-going debt crisis has forced many States to embrace the IMF and the World Bank, including Greece, as will be analysed in Chapter 6. As a result, the IMF and the World Bank discourage low-income States to increase the levels of health expenditure and especially due to the global financial crisis since 2009, which leaves limited space for decisions for increased international co-operation.[251]

Even 38 years ago the international community seems to be aware of these realities in that it conceded that 'the existing gross inequality in the health status

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248 Commission of the European Union, *Together for Health: a Strategic Approach for the EU 2008-2013*, White paper 630 COM, Brussels, 23 October 2007, pp. 6-10. <http://ec.europa.eu/health/ph_ overview/Documents/strategy_wp_en.pdf>

249 Ibid., p. 8.

250 World Bank, *World Bank Statistics –Health Expenditure 2012*, available at <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> accessed 6 March 2015. Of note, total health expenditure involves the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, but does not cover the provision of water and sanitation.

251 See, e.g., Working group on IMF programs, *Does the IMF constrain health spending in poor countries? Evidence and an agenda for action*, Washington, D.C.: Center for Global Development and Health Spending, June 2007.

of people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.'[252] Meanwhile, the current financial crisis could be an opportunity rather than an obstacle in order to introduce a new concept of promoting an international response for realizing the right to health for all people. In recent years, high-income countries in the European region have expressed their willingness to encourage the development of social health protection in the low-and middle-income countries of the world. For instance, in June 2007 at the 'G8' (the group of the eight biggest economies worldwide) summit in Heiligendamm (Germany), two European countries, Germany and France, introduced their 'Providing for Health' (P4H) initiative. By way of background, the 'Consortium on Social Health Protection in Developing Countries' -composed of the German development agency Gesellschaft für Technische Zusammenarbeit (GTZ), the ILO, and the WHO- prepared this initiative, in which France as well as other countries and organizations (e.g., the World Bank) later joined. The aim of this policy initiative (P4H) is the development and extension of social health protection (SHP) and the promotion of universal health coverage (UHC) in low- and middle-income countries worldwide.[253]

4.5. CONCLUSIONS

From this chapter it appears that the national context largely determines the specific content of measures required by States to realize the right to health within their jurisdiction. States retain a wide margin of appreciation in selecting the measures for implementing their right to health obligations. Nevertheless, it has been clearly established that there are some limits on how States seek to abide by their right to health obligations. In particular, States should demonstrate the adoption of deliberate, concrete and targeted measures; the time frame in which steps were taken; the allocation of available resources in accordance with human rights standards; the exhaustion of alternative and less restrictive measures; the non-discriminatory and non-arbitrary nature of the proposed measures; and the prioritization of the needs of the most vulnerable groups. In other words, States

252 *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma Ata USSR, 6-12 September 1978, § II.

253 GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries (2007) Website, Home page: <http://www.socialhealthprotection.org> (accessed on 2 January 2012); See also, website of P4H-Social Health Protection Network <http://p4h-network.net> (accessed on 21 April 2016)

are required to adopt a process that will determine the reasonableness of their actions (i.e. measures taken) towards realizing the right to health within their jurisdictions. Nonetheless, the notion of 'reasonableness' still remains highly generalized and requires considerably more detail for enabling the assessment of whether a State has engaged in a reasonable decision-making process for realizing the right to health within its jurisdiction. To this aim, domestic jurisprudence can be of particular assistance, in that it elaborates further on this notion and as such it could facilitate its application. In fact, in terms of the national recognition of the right to health, States must ensure that effective remedies are provided for every individual in order to give effect to his/her right to health. Despite the debate over the justiciability of the right to health in court proceedings, in Europe the work of the ECSR has produced a number of interesting (non-binding) decisions which interpret the right to health alone or in conjunction with other health-related rights. Such decisions may rightly seize the attention of future domestic court decisions regarding cases on the right to health. In any case, it is important to note that whatever measures adopted by States these must result in the effective implementation of their right to health obligations.

Meanwhile, the progressive realization of the right to health concedes that States must identify and prioritize the needs of vulnerable population groups, even in times of resource scarcity (i.e. adoption of low-cost programmes). As identified, vulnerable population groups (e.g., children, minorities and undocumented migrants etc.) do not have the same opportunities than others to achieve the highest attainable standard of health on the basis of their own efforts. They therefore require, to a larger extent than the ordinary population that States give special consideration to their special and diverse needs through the adoption of targeted measures that respond to these needs. To this aim, a comprehensive national strategy is required that is qualified by certain principles, involving the principles of accountability, transparency and participation of all beneficiaries, including marginalized groups. Note also that States' measures to realize the right to health of children must also be age-adjusted and consistent with four principles: the non-discrimination (Art. 2), the best interests of the child (Art. 3(1)), the child's right to life, survival and development (Art.6) and the child's right to express her/his views freely in all matters affecting her/him (Art.12)).

At the same, it appears that the definition of the type of state measures alone is not sufficient for States to abide by their obligations under the right to health given the progressive nature of this right and the different level of development among countries. As such, this process needs to be complemented by the clause of 'to the maximum of its available resources' within a State's jurisdiction.

Importantly, resource availability is another decisive factor that influences the degree of a State's compliance with its right to health obligations. Generally, the clause 'to the maximum of its available resources' may be seen as providing a considerable discretionary power to States as to the definition and calculation of such resources. However, this is not the case. Resources should be understood to include not only financial resources but also other types of resources, such as informational, human, natural and administrative resources. Therefore, under the obligation to make use of maximum available resources for realizing the right to health, States are required to ensure that adequate resources are available for health as well as to prioritize financing for health in their national budgets. As to the calculation of such resources, this should be primarily informed by the core content of the right to health, whose funding costs establish a 'funding baseline'. Moreover, as regards health funding prioritization, such process involves careful planning in setting concrete (policy) priorities and targets alongside other core funding commitments, such as education and social security, while avoiding misallocation/mismanagement of resources and corruption. In doing so, restrictions of States in available resources must be justified on a basis of a context-sensitive approach (i.e., country context), involving *inter alia* a country's economic situation and level of development.

In addition to national (limited at times) resources for health, States, given their level and rate of development, must sought to generate resources for health, involving financial and human resources, by means of international co-operation. It was established that international co-operation -albeit its parameters not yet fully elucidated- forms part of the state obligations for realizing the right to health. Here, it must be conceded that international co-operation cannot be overlooked due to the health consequences of poverty and financial hardship as well as the various significant transnational health risks, such as the Ebola epidemic. Meanwhile, the nature of the state obligation for international co-operation is not absolute as it was discerned that this obligation depends on each State's capacity (i.e., availability of a State's resources). This, however, alludes that developed States with greater resources and capacities at their disposal have assumed an enhanced role to realize the right to health in other less developed States.

Last but not least, it must be conceded that the limitation of the right to health in the adoption of a legislation or policy, namely a step back in the level of protection of the right to health (e.g., a reduction of public health expenditure) on the part of a State requires a justification. Otherwise, the absence of such justification can be construed as a State's non-compliance with its right to health obligations and hold the State accountable for a violation of the right to health.

Thereto, it is essential to dissociate a State's unwillingness to comply with its right to health obligations from a State's incapacity to do so.

All in all, this chapter attempted to articulate an account as to the scope of state measures required for the realization of the right to health, while keeping in mind that there is no 'one size fits all' action plan. It was illustrated that the obligations arising from the right to health largely depend on national contexts (i.e., economic situation, level of development, vulnerable groups) and have to be elucidated with greater precision in those discrete contexts. Thereto, the main burden falls on each State to adopt targeted measures for the discrete situations and groups within its jurisdiction in line with the existing domestic conditions. From this perspective, the articulation of state measures is further elaborated by way of a country case study in Part II. Particularly, the next step is to examine how the international standards set out in Part I, namely in chapters 2, 3, 4, are applied (or not) in a country case study, namely on Greece.

PART II

STATE PRACTICE: GREECE AS A CASE STUDY

5 Constitutional Entrenchment of Health as a Right

5.1. INTRODUCTION

The Constitution of Greece (in Greek: Syntagma, henceforth: the Constitution) that is in force today, was adopted in 1975, one year after the collapse of the dictatorship in Greece and the endorsement of parliamentary republic as a form of government by a referendum of the people. Since its adoption, the Constitution has been amended three times, particularly in the revisions of 1986, 2001 and 2008. Currently, in light of the preceding analysis in Part I, Greece is a party to most of the international and regional human rights treaties that guarantee a right to health, including the ICESCR, the CRC, the CEDAW, the ICERD, the CRPD, and the RESC (see Part I, section 2.2 and 2.3, and Annex 2).[1] Meanwhile, after ratification, international human rights treaties that contain a right to health have been incorporated into national law and can be applied before the Greek national courts.[2] In this regard, since 1975 the Constitution stipulates in its Article 28 § 1 that international treaties ratified by statute shall become an integral part of domestic Greek law, and shall prevail over any contrary provision of the law.[3] Moreover, since 1975 the significance of the incorporation of international law is underlined

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1 Up until 30 June 2016, Greece had not signed/ratified and incorporated into national law the UN MWC; See also, Annex 2.

2 Note that Article 93 § 4 of the Constitution provides that 'the courts shall be bound not to apply a statute whose content is contrary to the Constitution'.

3 The *Constitution of Greece (1975-1986-2001-2008*), as revised by the parliamentary resolution of 27 May 2008 of the VIIIth Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue Α′ 120/27-06-2008. The texts of the Constitution of Greece are the Official translation of the Hellenic Parliament available at <www.hellenicparliament.gr>; Notably, Article 100(1)(f) of the Constitution provides that the Special Highest Court is responsible for 'the settlement of controversies related to the designation of rules of international law as generally acknowledged in accordance with article 28 paragraph 1'.

in Article 2 § 2 of the Constitution, which stipulates that 'Greece, adhering to the generally recognized rules of international law, pursues the strengthening of peace and of justice, and the fostering of friendly relations between peoples and States'.[4] It is also noteworthy that Article 2 § 2 is placed in the section entitled 'Form of Government', thereby reflecting the prominent position of international law as part of the national legal order given by the constitutional legislator. Importantly, the wording of the two aforementioned constitutional provisions constitutes a foundation for interpreting and applying the Constitution in conformity with international law, while reflecting the significance of international perspective within national legal order.[5]

Notably, as regards the internationally guaranteed human right to health, in addition to the incorporation of human rights treaties containing this right in the national legal order, Greece has entrenched health as a right in its Constitution, which determines the scope of health legislation and policy, as will be elaborated in chapter 6. Hence, this chapter explores the constitutional entrenchment of the right to health in Greece. Particularly, section 5.2 will provide an analysis of the key elements of the constitutional framework of the right to health, including the elaboration of provisions on implementation of this right. After providing an account of the constitutional framework of the right to health, section 5.3 will address the relevance of other constitutional articles for the right to health, namely their influence on the realization process of this right.

But firstly, we need to briefly elucidate the role of the Council of State, whose judgments will be referred to below for the purposes of our analysis. The Council of State (in Greek: Symvoulio tis Epikrateias, StE) constitutes the Supreme Administrative Court of Greece. Under Article 94 § 1 of the Constitution the Council of State is generally authorized to decide upon matters of administrative (annulment) disputes.[6] Particularly, Article 95 § 1 of the Constitution provides that the jurisdiction of the Council of State pertains primarily to: 'a) The annulment upon petition of enforceable acts of the administrative authorities for excess of power or violation of the law, b) The reversal upon petition of final judgments of ordinary administrative courts, as specified by law, c) The trial of substantive administrative disputes submitted thereto as provided by the Constitution and the

4 Ibid.

5 Note that an interpretative clause was added to Article 28 in the 2001 revision of the Constitution which stresses that 'Article 28 constitutes the foundation for the participation of the Country in the European integration process'.

6 Ibidem supra note 3.

statutes and d) The elaboration of all decrees of a general regulatory nature'.[7] It is also notable that the judgements of the Council of State create important legal precedents for the lower administrative national courts as well as set the standards for the interpretation of the Greek Constitution and national laws. All in all, through its case law the Council of State tends to contribute to the advancement of legal theory and practice in Greece. Last but not least, the Council of State is member of the Association of the Councils of State and Supreme Administrative Jurisdictions of the European Union (ACA-Europe) as well as of the International Association of the Supreme Administrative Jurisdictions (IASAJ).[8]

5.2. KEY ELEMENTS OF THE RIGHT TO HEALTH IN THE CONSTITUTION

Before examining the key elements of the right to health in the Constitution, it is worth mentioning, by way of background, that the supreme legal status of the Constitution within the national legal framework is ensured and set out in several constitutional provisions. For instance, Article 110 of the Constitution bans the revision of certain constitutional provisions and stipulates a specific strict procedure to be followed by the Parliament for the revision of all others. Further, Articles 93 § 4 and 87 § 2 impose on the judiciary the duty of not applying and reviewing a law in case it is contrary to the Constitution (e.g., domestic health legislation that is opposed to the right to health or other health-related rights as contained in the Constitution). Moreover, Article 111 § 1 stresses that any previous rules (i.e., provisions of statutes or of administrative acts of regulatory nature) contrary to the Constitution will be abolished.[9]

As regards the definition of health as a constitutional right, it is noteworthy that such definition was first provided in Article 27 § 3 of the 1968 dictatorial Constitution, which stressed that 'the State shall care for the health and social security of the population as well as for the possession of housing as regards the deprived persons'.[10] However, the 1968 Constitution was revoked by the 1974 government and thereby it cannot be considered as an official document of the Greek State. As a result, the actual recognition of health as a constitutional right was embedded in Article 21 §

7 Ibidem supra note 3.

8 See Website of the Council of State <www.ste.gr>.

9 Ibidem supra note 3.

10 K.G. Mavrias & A.M. Pantelis, *Constitutional texts- Greek and Foreign*, Athens - Komotini: Ant. N. Sakkoulas 1981, p.147.

3 of the 1975 Constitution, namely prescribed as the State's duty, and later was supplemented by Article 5 § 5, which was added to the Constitution in the 2001 revision (i.e., the second revision, with the latest -third- revision taken place in 2008) and laid down the right of every person to the protection of health.[11]

5.2.1. ARTICLES 5 § 5 & 21 § 3 OF THE CONSTITUTION

As already noted, in addition to the international treaty provisions, the Constitution recognizes an individual right as well as a general obligation on the part of the State with respect to the protection of health. In particular, the Constitution in Article 5 § 5 provides that 'all persons have the right to the protection of their health and of their genetic identity…'. As such, the Constitution makes an explicit reference to the right to the protection of health, being applicable to every person residing in Greece. At the same time, the wording of this provision implies that both the State and non-State actors are under the obligation to abstain from actions that will violate the well-being of individuals or restrict their freedom to decide themselves for health-related matters.[12] Notably, Article 5 § 5 complements and supports the protection of health, also enshrined as a State's duty in Article 21 § 3 of the Constitution. Hence, the Constitution not only defines health as a right, but also articulates the duty of the State to take measures to protect the health of the population. Accordingly, Article 21 § 3 of the Constitution stresses that 'The State shall care for the health of citizens and shall adopt special measures for the protection of youth, old age, disability and for the relief of the needy'.[13] Contrary to the human rights provisions (see Part I, chapter 2), the strength of Article 21 § 3 does not lie in the word 'care', which lacks precision in that it is not accompanied by a list of specific measures required for the protection of health. Such a word implies a relatively modest commitment to health on the part of the State.[14]

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[11] *The Constitution of Greece* as voted under the parliamentary resolution of 7 June 1975 of the Vth Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue Α′ 111/09-06-1975; *The Constitution of Greece (1975/1986)*, as amended by the parliamentary resolution of 6 April 2001 of the VIIth Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue Α′ 85/18-04-2001.

[12] K. Chrisogonos, *Civil and social rights*, Athens-Komotini: Ant. N. Sakkoulas publishers 2002, p. 213.

[13] Ibidem supra note 3.

[14] See, Parliament of Greece - Vth Revisionary (Period Α′-Synod Α′), *Official Records of Parliament's Sessions* (presidency: K. E. Papakonstantinou), Volume Β′ (sessions ΜΘ′ - Π′) 6 March 1975- 27 April 1975, Athens 1975. Note by way of background that at the time of the drafting process of Article 21§ 3 of the Constitution, initially Article 23 § 3, instead of

Meanwhile, Article 21 § 3 involves a general and open-ended positive obligation on the part of the State to take steps in order to ensure the health of its *citizens*. Thereby, this provision, in principle, gives public authorities a wide margin of discretion in the measures required for the effective implementation of the right to health. Indeed, this provision implies that the State is required to take measures, *inter alia,* by enacting legislation for the purpose of: establishing an appropriate health infrastructure; regulating the health sector towards a high level of health care provision; and preventing the activities of third parties, namely of the various (public or private) actors in the health sector, from interfering with constitutional guarantees to health.[15] In Chapter 6 we will examine how Greece satisfies (or not) this requirement in practice, namely its obligation to secure the realization of the right to health.

A further argument with respect to Article 21 § 3 is that even though this provision is limited (in principle) to the Greek *citizens* as well as lists a number of particular groups to be granted special care by the State, the legislature may extend this protection to other population groups, including non-nationals. In fact, such practice would be in line with the binding obligations under international treaties that Greece has ratified and with Articles 5 § 5 and 2 § 1 of the Constitution (the principle of human value). However, given that the Constitution does not provide conceptual clarity with regard to the content of the term *citizens*, this would imply that Article 21 § 3 applies to *non-citizens* (e.g. migrant workers) who meet certain legal conditions, such as lawful residence or regular work in Greece. Nevertheless,

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adopting a general statement for the protection of health, the opposition parties, constituting the minority, had suggested the clarification of the meaning of the word 'care' in the constitutional provision by including practical measures (e.g. the provision of medical, hospital and pharmaceutical care) and a strong commitment on the part of the State at a separate article, Art. 23a (see session of 24 April 1975, pp. 2195-2198 and session of 26 April 1975, pp. 2235-2244).

[15] See, e.g., Judgment of the Administrative Court of Appeal of Piraeus, No. 1048/1994 regarding a compensation case, available at <www.lawdb.instrasoftnet.com>. Accordingly, it was stated that 'Article 21§ 3 of the Constitution, which stipulates that the State shall care for the health of the citizens, imposes a direct constitutional obligation on the State and the public law legal entities in the health sector, within which the respective state care is delivered, to adopt positive measures for the protection of health of the citizens and the provision of high standard health care to everyone who is entitled to demand the realization of the respective state obligation'; Judgment of the Council of State (StE), No. 43/2000 cited in Armenopoulos Journal, March 2000, issue 3, pp. 428-429. The Supreme Administrative Court held that the denial of health care to an elderly patient on the basis of selection criteria, namely his advanced age (old age), is contrary to Article 21 § 3 of the Constitution (p. 429); Ibidem supra note 12, K. Chrisogonos, p. 514.

such a discretion as to the definition of the term *citizens* does not imply that the Greek authorities operate in a vacuum. As will be elaborated in Chapter 7, the Greek State has adopted respective legislation and policy documents that interpret the relevant constitutional provisions. Along similar lines, Chapter 6 will set out an elaborate body of health-related law that tends to operationalize Articles 5 § 5 and 21 § 3 of the Constitution and regulate several aspects of the health care sector, involving preventive health care, health care financing and delivery.

5.2.2. IMPLEMENTATION OF ARTICLES 5 § 5 & 21 § 3 OF THE CONSTITUTION

As mentioned earlier, Article 21 § 3 in conjunction with Article 5 § 5 of the Constitution imposes on the State a general positive obligation to 'care' for the population's health with the ultimate aim to realize the right to health of every individual. However, the realization of this constitutional obligation is intertwined with the general policy adopted by the State. In this regard, Article 82 § 1 of the Constitution stipulates that the general policy of the Country shall be defined and determined in accordance with the provisions of the Constitution and the laws.[16] The general policy involves, *inter alia*, the economic policy, namely the allocation and prioritization of resources for the realization of constitutional obligations. As such, this means that the State is required to adopt an economic policy towards the fulfillment of its constitutional obligations, including the special care for the health of the population at large.[17] Nonetheless, like most European countries, Greece is grappling with the rising costs of its public sector, especially since the emergence of its economic crisis, primarily from 2010 onwards. In relation to expenditure on health, the Greek Ombudsman for Health and Social Solidarity (see section 6.2.2) in his annual report of 2010 has pointedly emphasized that the restriction of rights, including the right to health, on the basis of fiscal criteria, involving securing public funds and curtailing of costs, cannot be considered lawful.[18] Nevertheless, given

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[16] Ibidem supra note 3.

[17] Nevertheless, it is noteworthy that at the Vth Revisionary Parliament, a member of Parliament (A. Katsaounis) stressed that the state's policy must be based on the status that the Country can support economically, socially and politically, and that the economic status of the Country does not permit the adoption of a strong constitutional commitment on the part of the State regarding health (namely the economic status of the Country at the time of the drafting) (supra note 14, p. 2237).

[18] G. Sakellis, 'Social rights in time of crisis', in: *Annual report 2010 Greek Ombudsman*, Athens: State printing 2010, p. 68; Note that the role and authority of the Greek Ombudsman for Health and Social Solidarity are elaborated in section 6.2.2.

the fact that the State's budget is generally limited, State's policy choices must be made within these limits over the allocation of resources necessary to enable effective implementation of constitutional rights, such as the right to health.[19]

In light of the preceding analysis, the question that arises is what level of resources must be allocated to the health budget by the Greek State without displacing other competing rights, given the fact that the Greek State must also consider other competing areas, involving education, defence, justice etc (see Part I, section 4.2.3). The answer to this question is related to the interpretation of Article 82 § 1 of the Constitution in conjunction with the respective right to health obligations that the Greek State has undertaken under constitutional and international law. As such, the Greek State will decide on the allocation and prioritization of available resources and their respective level in order to fulfill its right to health obligations as well as the other competing obligations (see Part I, 4.2.3). At this point, it is worth mentioning that on the basis of Part I, this margin of discretion in relation to the level of resources to be allocated by a State is given also by human rights bodies, like the CESCR (see Part I, section 4.2.1).

Meanwhile, Article 21 § 3 in conjunction with Article 5 § 5 of the Constitution does not preclude privatization as being incompatible with the State's obligation to care for the protection of population's health. With respect to private initiative in the health care sector, such initiative is not explicitly addressed in the Constitution of Greece and a significant margin of appreciation is accorded to the Greek State with respect to this issue. Under its respective right to health provisions, the Constitution, thereby, neither suggests nor bans privatization in health care sector as a complementary measure to secure the health of the general population. The Greek State is entitled to adopt either a public or a private- public funding mixed system that it considers to be appropriate for achieving its national health goals. Even at the time of the session of the Vth revisionary parliament, concerning this provision (initially Article 23 § 3) a reference was made at the potential role of private actors in the provision of medical care.[20] A similar approach has been also endorsed by national judicial bodies. With respect to case law, in a decision of 1997 the Council of State (henceforth: the Council) ruled that the State has to strengthen the efforts of private actors towards providing appropriate and of good quality health care to

[19] For an analogous approach, see, e.g., P. Dagtoglou, *Individual rights – vol. B'*, Athens-Komotini: Ant. Sakkoulas 1991, p. 1235.

[20] Ibidem supra note 14, p. 2196. Accordingly, it was suggested by a member of the Parliament (Th. Manavis) the establishment of sanitary institutions by non-state actors until the State could cover the health needs of the population.

the population as well as introduce supervisory mechanisms.[21] In this regard, the Council also stressed that Article 21 § 3 does not promote solely the public provision of health care and, for that reason, it called on the provisions of the ESC, namely Articles 11, 13 and 14 of the ESC, which promote the collaboration between public and private actors in the field of health care provision.[22] Here, it is important to note that both the ESC and its revised version have been incorporated within national legal order by Law 1426/1984 and Law 4359/2016, respectively (see Annex 2).

At the same time, the private initiative in health care provision is also supplemented by every individual's right to develop freely, embedded in Article 5 § 1 of the Constitution. Article 5 § 1 underpins that 'all persons shall have the right to develop freely their personality and to participate in the social, economic and political life of the country, insofar as they do not infringe the rights of others or violate the Constitution and the good usages'.[23] However, the economic freedom afforded to private actors under this provision remains subject to certain requirements which are determined by the legislature, for instance as to the nature of measures taken by them in the field of health care provision (see section 6.5.1). It is on this basis that Article 106 § 2 of the Constitution stresses that 'private economic initiative shall not be permitted to develop at the expense of freedom and human dignity, or to the detriment of the national economy'.[24] With regard to the privatization in health care, this provision alludes that the design and delivery of health care under a system of privatization must be consistent with the principle of human dignity at all stages as to ensure that such a system is contributing to the well-being of the general population. Anything less would constitute a threat to the purpose of the right to health as well as to human dignity under this constitutional provision. Nonetheless, beyond this broad scope of protection, under this constitutional provision it is not clarified how this will be managed, namely a clear account of the measures required to secure the implementation of this provision is not provided. In practice, this means that the Greek State is required to create some institutional or regulatory framework to ensure monitoring of implementation as well as transparency of the process (see sections 3.7.1 and 6.5.1). All in all, it must be conceded that the Constitution guarantees a freedom of private activity in the health sector, while at the same time allowing a State intervention through legislative

[21] Council of State (StE) 1374/1997, 1 April 1997, available at <www.lawdb.intrasoftnet.com>; Of note, with respect to the jurisdiction of the Council of State, namely the Supreme Administrative Court, see Articles 94 § 1, 95 and 100 § 5 of the Constitution.

[22] Ibid., § 4.

[23] Ibidem supra note 3.

[24] Ibid.

measures for generally ensuring the well-being of the population as a whole.

Notably, as mentioned earlier, the wording of Article 21 § 3 implies that both the State and non-State actors are under the obligation to abstain from actions that will violate the well-being of individuals or restrict their freedom to decide themselves for health-related matters.[25] As such, the Greek State should not delay or even abandon its right to health obligations, enshrined both in the Constitution and in international law, by means of health care privatization (see Part I, section 3.7.1). In fact, in literature it is maintained that private actors are not concerned with enhancing general population's well-being, including deprived or uninsured population groups, such as undocumented migrants and Roma.[26] In essence, it is within the Greek State's power to prevent health disparities and provide for a health infrastructure to safeguard the health of the population as a whole. Indeed, the Constitution does not grant exclusively the provision of health care to private actors and, thereby, does not relieve the Greek State from its own primary and ultimate obligation under the respective right to health provisions. On the contrary, under Article 25 § 1 of the Constitution, the Greek State has the obligation to guarantee to every individual the exercise of his/her rights, including the right to health. In particular, following the revision of 2001 this provision explicitly establishes the principle of the welfare State that alludes to a national system of social assistance, including health care.[27] This statement provides supplementary safeguards (see below section 5.3), apart from the protection granted in specific constitutional provisions, mainly in Articles 5 § 5 and 21 § 3 of the Constitution.

Finally, even though the privatization in the field of health care is not inconsistent *ex costitutione* with the State's requirement to take measures to secure the health of the general population, this process must be subject to scrutiny with a view to addressing firmly the responsibilities of private actors and ensuring that privatization in the health sector contributes to the fulfillment of the health needs of the population as a whole (see sections 3.7.1 and 6.5.1). This implies that even though the Greek State will not be responsible for the delivery of health care, it will act as the guarantor of the right to health for all. Consequently, the Greek State should never undermine its primary and overall responsibility under national law, namely Article 21 § 3 of the Constitution, and under international law towards the

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[25] See, also, P. Dagtoglou, *Individual Rights - vol. A'*, Athens-Komotini: Ant. Sakkoulas 1991, p. 202.

[26] B. Toebes, 'The Right to Health and other Health-Related Rights' in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.) *Health and Human Rights in Europe*, Cambridge/Antwerp/ Portland: Intersentia 2012, pp. 83-110.

[27] Ibidem supra note 3.

protection of the health of the general population. As will be elaborated in Chapter 6 (see section 6.5.1), the Greek State has adopted respective health-related legislation for the purpose of regulating some aspects of the behaviour of private healthcare providers.

5.3. OTHER CONSTITUTIONAL ARTICLES

As mentioned in Part I the right to health is closely connected to and supported by other rights that have the potential to protect and promote health (see Part I, chapter 2). Notably, beyond the formulation of health as a constitutional right, the Constitution encompasses also several other rights that have a health dimension and influence the realization of the right to health. Some of these rights will be discussed briefly below and where relevant, references will be made to other sections (for example, see section 7.3.2). As noted earlier, of particular interest is Article 25 § 1 of the Constitution which stipulates that 'The rights of the human being as an individual and as a member of the society and the principle of the welfare state rule of law are guaranteed by the State …'. [28] The wording of this constitutional provision gives rise to an obligation on the Greek State to take measures to secure the enjoyment by every individual of all constitutional rights, including the right to health.

Meanwhile, the aforementioned provision should be read in conjunction with Article 5 § 2 of the Constitution, implicitly guaranteeing the right to life, whilst at the same time explicitly embracing the principle of non-discrimination. In particular, it declares that 'all persons living within the Greek territory shall enjoy full protection of their life, honor and liberty, irrespective of nationality, race or language and of religious or political beliefs. Exceptions shall be permitted only in cases provided by international law'.[29] This provision has a health-related dimension in that it can be relevant in relation to matters concerning access to health care for vulnerable population groups, such as undocumented migrants, Roma children etc. (see e.g., chapter 7). For example, it may imply that healthcare provision must be defined according to the medical need of the individual and regardless of nationality, race etc.

Furthermore, the protection of the environment, embedded in Article 24 of the Constitution, is an important aspect of the right to health (see Part I, chapter 2). Accordingly, Article 24 § 1 (a) provides that 'the protection of the natural and cultural environment constitutes a duty of the state and right to every person'.[30]

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[28] Ibidem supra note 3.
[29] Ibid.
[30] Ibid.

In this regard, with respect to case law, the Council of State has repeatedly acknowledged in its decisions the relation between health and environment. For instance, in a decision of 1983, the Council established a link between Article 24 § 1 and 21 § 3 of the Constitution.[31] Similarly, in decision 1874/1994, the Council ruled that Article 24 of the Constitution imposes on the State the obligation to protect the natural environment based on its responsibility to secure the health of the population, which arises from Article 21 of the Constitution, as well as on its responsibility to ensure the protection of ecosystems and biotopes, involving also the protection of diversity. Additionally, the Council in its ruling stressed that in case of conflict between the two provisions, the protection of health should be prioritized.[32]

Moreover, there are links between one's state of health and one's enjoyment of human dignity and freedom from inhuman and degrading treatment, enshrined in Articles 2 § 1 and 7 § 2 of the Constitution, respectively, which apply to all individuals regardless of nationality (see Part I, chapter 2). More specifically, Article 2 § 1 provides that 'respect and protection of the value of the human being constitute the primary obligations of the State'.[33] Additionally, Article 7 § 2 stresses that 'Torture, any bodily maltreatment, impairment of health or the use of psychological violence, as well as any other offence against human dignity are prohibited and punished as provided by law'.[34] As such, the protection of health is intertwined with the aforementioned rights in such a way to impose on the Greek State the duty to prevent individuals from exposure to health risks and refrain from undertaking measures detrimental to health by providing sufficient medical attention for all population groups, including undocumented migrants, especially those held in detention centers (see chapter 7).

Last but not least, the enjoyment of the right to private and family life, embedded in Article 9 § 1 of the Constitution combined with Article 5 § 1 on the freedom to develop one's personality, embraces issues, which are relevant in a healthcare setting, relating to personal autonomy (informed consent), the disclosure of information on private, personal existence. In this regard, with respect to case

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31 Council of State (StE) 3458/1983, index StE 1983, p. 1232.

32 Council of State (StE) 1874/1994, 7 June 1994, § 7, available at <www.lawdb.intrasoftnet.com>

33 Ibidem supra note 3; It is noteworthy that Article 2 § 1 is supplemented by Article 5 § 1 of the Constitution which guarantees every individual's right to develop freely his/her personality and participate in the social and economic and political life of the country, as long as he/she does not infringe upon the rights of others or violate the Constitution and the good usages (moral values).

34 Ibid.

law, the Council of State has found that the protection of one's sexuality can be addressed under Articles 9 § 1 and 2 § 1 of the Constitution.[35]

5.4. CONCLUSIONS

In this chapter, the analysis of several constitutional provisions relevant to health has been used as a starting point for answering the question how the internationally guaranteed right to health has been recognised and applied in national law. Importantly, since 1975 the Constitution of Greece attaches growing significance to the role of international law within domestic legal order, through including special clauses on the domestic applicability and supremacy of international treaties in constitutional provisions. In addition to the recognition and integration of international law that, *inter alia*, contain a right to health, in national legal order, the Constitution contains two Articles, that complement each other, namely entrench health both as a right and as a state's general duty with particular consideration for the youth, elderly, disabled persons and for the relief of the needy. This constitutional open-ended framework is a valuable aspirational statement on which national legislation and policy practices can be based. Notably, the entrenchment of health as a right and as State's duty in the Constitution plays partly an important symbolic role in indicating the State's commitment to the right to health. But such a symbolism must also be accompanied by specific measures taken by the Greek State to implement such a commitment for the effective realization of the right to health of every individual in practice.

In this regard, one may agree with Ruth Roemer that 'The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens. A statement of national policy alone is not sufficient to assure entitlement to health care; the right must be developed through specific statutes, programs and services. But setting forth the right to health care in a constitution serves to inform the people that protection of their health is official policy of the government and is reflected in the basic law of the land'.[36] Clearly, the operationalisation of the right to health is both a cardinal issue and a challenge that will be elaborated in the following chapters.

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[35] Council of State (StE) 3545/2002, 3 December 2002, § 10, available at <www.lawdb.intrasoftnet.com>

[36] R. Roemer, 'The Right to Health Care' in: H.L. Fuenzalida-Puelma & S. Scholle Connor (eds.) *The Right to Health in the Americas: A Comparative Constitutional Study*, Washington, D.C.: Pan American Health Organization (Scientific publication No. 509) 1989, pp. 17-23, p. 20 (cited also in: V.A. Leary, 'The Right to Health in International Human Rights Law', *Health and Human Rights* 1994, Volume 1, Issue 1, pp. 25-56, p. 35).

6 Health Infrastructure

6.1. INTRODUCTION

Generally speaking, under international law States, as primary duty holders, are required to undertake a number of measures (i.e., involving legislative, administrative, policy and other measures) to the maximum extent of their available resources in order to realize the right to health of every individual within their jurisdiction (see Part I).[1] In practical terms, this implies, *inter alia*, that at the national level, States are obliged to adopt a detailed national health plan that is compatible with their right to health binding obligations. Thereto, States have an implicit positive obligation to take measures, *inter alia*, to adopt legislation on the provision of a comprehensive health care delivery towards ensuring the right to health of every individual in an effective manner within their jurisdiction. Notably, it is within this context that the ECtHR in its case law has interpreted this positive obligation as requiring of States to e.g. issue adequate health-care regulations that compel hospitals (public or private) to adopt appropriate measures for the protection of their patients' lives.[2]

Meanwhile, due to different health levels and needs among countries, most actions occur at the national level by way of adopting laws and policies to meet the right to health obligations imposed. As observed in Part I, over the years, there is a growing attention to health systems within the human rights system with respect to their dynamic for promoting population and individual health and realizing the

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1 See, e.g., Article 2(1) CRC: 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction…'; Ch.R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, p. 114.

2 See, e.g., *Arskaya v. Ukraine* (Application no.45076/05) ECtHR 5 December 2013, §§ 62-63, 84 and 91; *Calvelli & Ciglio v. Italy* (Application no.32967/96) ECtHR 17 January 2002, § 49.

right to health of every individual (see Part I, section 4.2.3).[3] As such, State's attention to health systems can be a way to create favorable conditions that enable people to maintain and improve their health status as well as prevent health disparities and threats to individuals' health (see Part I, section 3.7). In the meantime, it is widely accepted that health care systems produce better health outcomes when priority is given to primary health care.[4] Elements of primary health care constitute an integral part of the core content of the right to health -albeit a controversial concept requiring due caution- and encompass a wide range of issues, more than health care services, such as health education (Part I, section 3.4). However, the role, the functioning and actual content of primary health care in a country is defined and determined by the prevailing specific national circumstances and particularities. At the same time it must be conceded that States are required to establish a primary health care system that is widely available, accessible, affordable, and of good quality, through the appropriate allocation of existing (even scarce) resources (Part I, sections 3.5 and 4.2.3).

Thus, building on the preceding analysis of Part I, we will examine Greece in relation to its compliance with a specific State obligation to provide health care in the context of implementing the right to health, enshrined in the Greek constitution as well as in international documents that are binding for Greece. This international obligation has set the stage for the adoption of national definitions that reflect their particular circumstances and starting points. Thereby, the aim of this chapter is to examine the parameters set around the aforementioned State obligation within Greek law-policy context through focusing on how the right to health features in the Greek National Health System (NHS). Notably, in terms of this objective, we will focus on the core of the National Health System in Greece (section 6.2) with attention on recent efforts to strengthen the functional framework of primary health care (section 6.3). Subsequently, we will define in section 6.4 to what extent the Greek NHS has integrated in its articulation and functioning

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[3] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 62nd Sess., Agenda Item 10*, UN Doc. E/CN.4/2006/48, 3 March 2006, § 4; See, also, Part I, Section 4.2.3.

[4] See, e.g., CSDH, *Closing the gap in a generation: Health equity through action on social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva: World Health Organization 2008, p. 8; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 7th Sess., Agenda Item 3,* UN Doc. A/HRC/7/11, 31 January 2008, §§ 21, 55 and 90.

recognised components of the right to health (the so called 'AAAQ'). Finally, two challenges within the Greek NHS, namely privatization of the provision of health care and public health sector corruption, which signal dangers for the objectives of the right to health, will be addressed in section 6.5. At this stage, it is noteworthy that while acknowledging that the right to health also includes the underlying determinants of health, the analysis in this chapter will focus on 'health care', an important component of the right to health.[5]

6.2. THE NATIONAL HEALTH SYSTEM IN GREECE

6.2.1. SETTING THE SCENE

In 1983, the State's obligation under Article 21 § 3 of the Greek Constitution (see section 5.2.1) as well as under treaty law (e.g., Articles 2 § 1 and 12 ICESCR) was implicitly reflected in the establishment of the Greek National Health System (in Greek: Ethniko Systima Ygeias, ESY), which seemed on its face to be a progressive move towards health equity (see its section entitled 'general principles' - Article 1).[6] Generally speaking, in 1983 the structure and activities of the ESY were designed and planned under the general aim of optimum individual and population health in Greece (see below section 6.2.2), while no explicit references to international law and the Constitution were made within the text of the founding Law of ESY, Law 1397/1983.[7] Nevertheless, in recent years like other European countries, Greece was found to be struggling with the growing costs of its health system in terms of its hardly manageable fiscal problems, while at the same time trying (rather unsuccessfully) to maintain a social welfare State (see below section 6.4).[8] In fact,

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5 UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc E/C.12/2000/4, 11 August 2000, § 11.

6 Of note, prior to the establishment of the ESY by Law 1397/1983, the Greek State under Compulsory Law 965/1937 'Organization of public hospital and sanitary institutions' made an effort towards organizing public care, namely the operation of public hospitals, within a common framework and creating public primary health care.; Note that ICESCR in Greece constitutes a supreme national law, namely Law 1532/1985 (see section 5.1 and Annex 2) and in this respect the CESCR has expressed its appreciation in its concluding observations for Greece regarding the prominent position of the ICESCR within Greek legal order (UN CESCR, CO: Greece, UN Doc. E/C.12/1/Add.97, 7 June 2004, § 4); See infra note 7.

7 Law 1397/1983, 'Establishment of the National Health System (ESY)', *Official Government Gazette* - ΦΕΚ issue A′ 143/07-10-1983; See also, E. Nolte & M. McKee, *Does Health Care Save Lives? Avoidable Mortality Revisited*, London: The Nuffield Trust 2004, pp. 9 and 79.

8 EPHA, *Reforming Health Systems in Times of Austerity -EPHA Position Paper*, Brussels: European Public Health Alliance (EPHA) Publications 2013, pp. 6-7.

WHO in a 2007 report revealed that health systems in many countries 'are on the point of collapse, or are accessible only to particular groups in the population'.[9] Meanwhile, as a way of background (i.e., as to obtain a more complete overview of the Greek State's health infrastructure) an introduction to the core of the ESY with emphasis on its primary care system and its various health reform initiatives will be provided in the below sections.

6.2.2. THE CORE OF THE ESY

As previously mentioned, the Constitution in Greece provided a roadmap for the enaction of relevant health legislation, most notably the establishment of the ESY in the country by Law 1397/1983. Indeed, Article 1 § 2 of Law 1397/1983 stresses that the Greek State has the full responsibility to provide health care equally to the population, irrespective of their financial, social and employment status through an integrated and decentralized national health system.[10] This provision does not recognize a right to health, but rather entails an obligation by using the term 'responsibility' on the part of the State combined with a consideration for the weaker members of the society, which altogether form the basis of the ESY. Moreover, ESY is organized around the main principle of universality in the distribution of health care, embedded in Law 1397/1983. This principle provides that every individual is entitled to access quality health care pursuant to his/her medical needs irrespective of income level or social status. All in all, in 1983 the design of ESY was initially geared towards the provision of comprehensive, equally distributed and good quality health care. Nonetheless, over the years Greece's national health system appears to be in a constant state of reform, as the Greek State seeks to control its hardly manageable and increasing health care costs. Here, it is important to stress that access to health care for certain groups of the population in Greece, such as undocumented migrants, is regulated by specific laws and not under Law 1397/1983 (see Part II, section 7.3). Meanwhile, five principal and interlinked aspects, partly reflecting some aspects of the right to health (see Part I, chapter 3 and section 4.2.3), constitute the core of the ESY and were introduced through the enaction of relevant laws (primarily under Law 1397/1983), as follows:

(i) *Decentralization* in the decision-making and in administrative processes, regulated under Law 1397/1983, Law 2889/2001 and Law 3329/2005. This process

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[9] WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes,* Geneva: World Health Organization 2007, p. 1.

[10] Law 1397/1983, 'Establishment of the National Health System (ESY)', *Official Government Gazette* - ΦΕΚ issue Α′ 143/07-10-1983.

implies that a health system must be responsive to local health needs and accessible to all. As a consequence, the health infrastructure and the accessibility of the population to health care, an essential element of the right to health, can be strengthened. However, the ECSR in its report for Greece expressed its concern about the accessibility of health care facilities in remote and rural areas. Notably, the Committee addressed disparities in health and access to health care for rural and remote populations.[11] At the same time, another issue of concern is that decentralization of health care makes difficult to monitor procurement of medical equipment and of pharmaceuticals, which poses high risks for corruption within the ESY (see below section 6.5.2). Consequently, decentralization proves to be counter effective, as it is not accompanied by a national strategy to combat corruption at local levels.[12]

(ii) *Accountability,* regulated under Law 1397/1983 (administrative monitoring), Law 2071/1992 (administrative monitoring and patients' rights - redress mechanism), Law 2920/2001 (financial and institutional accountability) and Law 3293/2004 (institutional accountability). Such a regulatory framework within the context of health care requires all those involved in the provision of health care to be held accountable for the discharge of their right to health duties. Indeed, without accountability mechanisms, the right to health (care) may become meaningless or ineffective for right holders.[13] In this spirit, the Greek State in an effort to strengthen the accountability process established primarily two significant institutional monitoring structures that accompany the function of the ESY, namely the Greek Ombudsman for Health and Social Solidarity (in Greek: Synigoros Ygeias kai Koinonikis Allilegyis) and the Body of Inspectors for Health and Welfare Services (in Greek: Soma Epitheoriton Ypiresion Ygeias kai Pronoias, SEYYP - applicable also for monitoring the actions and decisions in the private health sector). Of note, their overall mandate is closely linked to the realization of the right to health (care) in that such accountability mechanisms and processes strengthen the justiciability of this right (see Part I, section 4.3). These mechanisms enable individuals to hold the Greek State and other actors within the health sector to account for possible failures to realise their right to health (care) obligations.

More specifically, the Greek Ombudsman for Health and Social Solidarity was established by Article 18 of Law 3293/2004 as an independent authority and has

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11 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

12 European Commission, *Study on Corruption in the Healthcare Sector*, HOME/2011/ISEC/PR/047-A2, Luxembourg: Publications Office of the European Union 2013, p. 245.

13 E. Riedel, 'The Human Right to Health: Conceptual Foundations' in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 33.

various measures at his/her disposal.[14] This quasi-judicial authority is responsible for investigating, at his/her own initiative and/or after the submission of a complaint, administrative actions or omissions by organs of public health services, insurance funds, welfare services, namely cases of violations against either an individual's right to health (care), especially as regards to vulnerable population groups (i.e. elderly, poor, persons with disabilities etc.) regardless of nationality; or the legal interests of individuals; or legal entities.[15] In addition, this authority is responsible for providing advice to the Greek Ministry of Health involving the improvement of the operational framework of health care services and the elimination of misallocation of resources and mismanagement in health sector.[16] Nonetheless, the Greek Ombudsman for Health and Social Solidarity can only investigate cases that are not pending before a judicial authority and only if the authority involved and the complainant have failed to resolve the matter together.[17]

As aforementioned, when it comes to national monitoring (accountability) mechanisms, another important regulatory body connected to the realization of the right to health (care) is the SEYYP. The main tasks assigned to SEYYP, under the auspices of the Greek Ministry of Health, are to supervise public and private healthcare sectors on the detection of offences; to identify problems in the

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[14] Law 3293/2004 'Polyclinic of Olympic village, Ombudsman and other provisions', *Official Government Gazette* – ΦΕΚ issue Α′ 231/26-11-2004; Notably, the Constitution of Greece in Article 101A generally provides for the establishment and operation of an independent authority and in Article 103 § 9 stipulates the role of the Ombudsman without further elucidating its duties. Accordingly, Article 103 § 9 provides that 'Law shall specify matters relating to the establishment and activities of the 'Ombudsman', who functions as an independent authority; See also, as regards the Greek Ombudsman founding Law 2477/1997, amended by Law 3094/2003 and PD 273/1999, *Official Government Gazette* – ΦΕΚ issue Α′ 229/03-11-1999 (regulations of the Greek Ombudsman). Note that the Greek Ombudsman is assisted in his duties by Deputy Ombudsmen in charge of the initially four corresponding departments (now six departments), among which the 'Social Protection, Health and Welfare' department established under Article 18 § 4 Law 3293/2004 <www.synigoros.gr>. The Greek Ombudsman and the Deputy Ombudsmen are selected by the Conference of Parliamentary Chairmen under Article 101A § 2 of the Constitution. Additionally, the Deputy Ombudsmen are appointed by the Minister of Interior on the recommendation also of the Greek Ombudsman. As regards the Ombudsman's authority, the Council of State in its 2274/2003 decision (§§ 16 and 18, 16/9/2003) has ruled that the actions and findings of the Ombudsman do not have executive character.

[15] Ibid.

[16] Ibid.

[17] Ibid.; Article 4(4) of Law 3094/2003, *Official Government Gazette* - ΦΕΚ issue Α′ 10/22-01-2003.

administration of health care providers and more generally in the delivery of health care; and to suggest solutions to the Greek Ministry of Health with a view to advancing public health in Greece.[18] In particular, based on its wide mandate it has three areas of work, from which the following forms of supervision can be discerned: 1) supervision of health care providers, namely overseeing the quality of health care services as well as of pharmaceuticals; 2) administrative and financial supervision of health care providers under the authority of the Greek Ministry of Health and 3) supervision of the functioning of welfare institutions, including nurseries, rehabilitation units and elderly care units etc.[19]

All in all, both authorities are generally concerned with promoting public health, improving the quality of health care as well as with strengthening transparency in the relationship between the various actors in the health sector, including ESY health personnel, hospitals, and the recipients of health care. The aforementioned institutions indicate that accountability, which is a core component of the right to health framework, is regarded to be central to enhancing the overall ESY functioning and is implicitly considered as a human rights concept in these institutional initiatives. Particularly, their operational framework refers to redress mechanisms - a critical part of accountability - for those who are victims of discrimination or face violations of the right to health in their engagement within or outside the ESY.[20] However, despite the legislative efforts to integrate a core human rights principle into policy, accountability within the ESY is extremely weak. Persistent corruption within the public health sector, a significant obstacle to the enjoyment of the right to health (see sections 3.7.2 and 6.5.2), constitutes a typical consequence thereof.[21]

(iii) *Integrated organizational framework of health care,* regulated under Law 1397/1983, PD 87/1986, Law 2889/2001 and Law 3329/2005. With main attention to enhancing timely access to quality health care, this framework, in principle, tends to contribute to the reduction of complexity in the procedures as well as to the promotion of participation, accountability and transparency into the design and

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[18] Law 2920/2001 'Creation of SEYYP', *Official Government Gazette* - ΦΕΚ issue Α΄ 131/27-06-2001, as supplemented and amended by: Law 2955/2001, *Official Government Gazette*- ΦΕΚ issue Α΄ 256/02-11-2001, Law 3204/2003, *Official Government Gazette* - ΦΕΚ issue Α΄ 296/23-12-2003, Law 3252/2004, *Official Government Gazette* - ΦΕΚ issue Α΄ 132/16-07-2004 and Presidential Decree (PD) 278/2002, *Official Government Gazette* – ΦΕΚ issue Α΄ 244/14-10-2002.

[19] Ibid., Article 3.

[20] Ibidem supra note 5, GC No. 14, § 59 (emphasis on legal accountability).

[21] Ibidem supra note 12, European Commission.

implementation of health-related policies towards exposing corruption.[22] However, in practice there is a partial implementation of the relevant provisions, which affects adversely the delivery of health care, as will be elaborated in below sections.

(iv) *Primary health care*, regulated under Articles 5 and 14-19 of Law 1397/1983, PD 87/1986, Law 3235/2004, Article 18 of Law 3918/2011 and Law 4238/2014. In principle, various legislative initiatives embraced primary health care over time that tended to draw on the principles of Alma-Ata Declaration.[23] Nevertheless, in practice the impact of these legislative initiatives was rather limited, as Greece failed to implement a comprehensive primary health care integrated with an adequate referral system to secondary and tertiary health care. As a result, this failure led to disproportionate funding in secondary and tertiary health care and hampered the availability of health care, especially in rural and remote areas.[24] As such, in February 2014, the Greek State introduced a reform on the prioritization of primary health care, as will be further elaborated in section 6.3.[25] Meanwhile, it is important to note that in addition to the state provision, primary health care is provided also by private actors under Article 13 of Law 2071/1992.[26] Of note, as an analysis of the functioning of primary health care in Greece is to be found in the subsequent section, it is not necessary to repeat it here.

(v) *Members of the medical profession (i.e., physicians, nurses, pharmacists etc.),* employed by the Greek State to work on a full-time and exclusive basis within the ESY (i.e., state-led hospitals and health centers) primarily under Law 1397/1983, Law 2071/1992 and Law 2889/2001. Here, it must be conceded that the members of the medical profession working in the national health system (ESY) are regarded as state officials due to their state employment status. In fact, in literature it is pointedly submitted that members of the medical profession who form part of the State (i.e., being state officials) are directly bound by human rights law.[27] Meanwhile, it must be also acknowledged that members of the medical

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22 See generally, A.D. Alexiadis, *The NHS at the beginning of 21st century. The Effort of Law 2889/2001*, Thessaloniki: Dimopoulou Publishing 2001.

23 Declaration of Alma Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6- 12 September 1978, § VIII.

24 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

25 Law 4238/2014 on the establishment of a Primary National Health Network (PEDY).

26 Law 2071/1992, 'Modernization and Organization of the Health System', *Official Government Gazette* - ΦΕΚ issue A′ 123/15-07-1992; See section 6.5.1 with regard to the regulation of private health sector on the part of the Greek State by respective Presidential Decrees.

27 See, e.g., B. Toebes, 'Human rights and health sector corruption' in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 102-134, p. 121.

profession, whether employed by the Greek State (i.e., state officials) or a private health actor (i.e., not directly bound by human rights law - see Part I, section 3.7.1), bear a legal/professional responsibility towards patients under an extensive body of national binding regulations, such as Law 3418/2005 (the Code for Health Deontology).[28] Such regulations strongly focus on the protection of patient's rights in the health care system, including the notion of informed consent and the legal/professional duty of confidentiality, as will be elaborated in section 6.4.2.4. All in all, the medical profession and its suitably trained members play a critical role in the realization of the right to health (care) in the context of guaranteeing the key principles of acceptability and quality of health care services arising from this right (see Part I, sections 3.5 and 4.2.3).[29] Indeed, given the pivotal role of the medical profession and its continuing shortage, the CRC Committee in its 2012 report has recommended Greece '… to strengthen its health infrastructure, including through the recruitment of additional nurses and social workers'.[30] Such concern has been reiterated by the CESCR in its 2015 report for Greece.[31]

From the above analysis, it becomes obvious that the core of the Greek National Health System (ESY) does not expressly engage with human rights concepts, as it was not designed in light of human rights law. Nevertheless, it implicitly builds on human rights standards through its functioning, which aims at obtaining a balance between the population needs and their actual conceptualization to the broader legal and policy context within which the ESY is situated. As observed, in principle several laws have highlighted the significance of the notions of 'participation' and 'accountability' (see Part I, section 3.5) towards enhancing the health system's performance without, though, systematic attention to these, especially with respect to the participation process. More specifically, the notion of 'participation' has been

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[28] Law 3418/2005 'Code of Health Deontology', *Official Government Gazette* - ΦΕΚ issue Α′ 287/28-11-2005; Along similar lines, the nursing personnel is bound by the 'Code of Nursing Deontology' under PD 216/2001, *Official Government Gazette*- ΦΕΚ issue Α′167/25-07-2001; See also, E.A. Alexiadou, *General Principles of Health Deontology*, Thessaloniki: University Studio Press 2012 (provides an elaboration of the legal/professional duties of a number of health professionals in Greece, including doctors, nurses, physiotherapists, dentists, pharmacists etc.).

[29] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc. E/CN.4/2003/58, 13 February 2003, § 95; For an elaborate analysis on the employment status of health professionals in Greece, see, A.D. Alexiadis 2001 (supra note 22).

[30] UN CRC Committee, CO: Greece, UN Doc. CRC/C/GRC/CO/2-3, 13 August 2012, § 53.

[31] UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 35 and 36(b).

set forth through the decentralization process, the integration process and the design of primary health care, however, without further engagement by the Greek State within policy context (see sections 8.3.3 and 8.3.4), primarily due to lack of law enforcement, resulting to the partial implementation of relevant laws. As regards the overall functioning of the health care system, the notion of 'participation' is also embedded in the doctor-patient relationship, namely within the context of health decision-making though the adoption of respective law provisions (see section 6.4.2.4). On the other hand, the notion of 'accountability', while not explicitly, is integrated in the organizational structure of the ESY and, particularly, is conceptualized primarily through two institutional authorities, as aforementioned. In addition, the respective law provisions draw attention to the importance of redress mechanisms accessible to all and of transparency in the functioning of the ESY. Transparency, although not being a human rights principle, is associated with accountability and participation in that it requires public officials, civil servants, managers and directors of organizations to act visibly and promote participation and accountability by reporting on their activities for which the general public can hold them to account.[32] To conclude, the preceding analysis makes also clear that the Greek State has tended to meet the 'obligation to protect' (Part I, section 3.3), namely to regulate the position and activities of the several actors in health care sector, which will be further elaborated in section 6.5.1 as regards the private actors. Last but not least, notions of accessibility, availability and quality (see Part I, section 3.5) underpinning the right to health are in principle primary objectives in the context of laws and policies regulating the ESY. Nevertheless, the analysis of the core of the ESY does not allow for exhaustive conclusions about the application of human rights standards within the ESY, namely whether their implications are duly considered by the Greek State in practice. For that reason, an assessment of the performance of the ESY with respect to its compliance with four essential principles arising from the right to health framework will be applied below (see section 6.4).

6.3. THE PROMINENCE OF PRIMARY HEALTH CARE WITHIN THE ESY

In general, state reform measures in health care provision continue to focus on seeking a balance between the general population's needs and the increasing

[32] See, Transparency International (TI), *Anti-Corruption Glossary,* available at <www.transparency.org/glossary/term/transparency> accessed 17 September 2015; Ibidem supra note 5, GC No. 14, § 55. The CESCR refers to transparency in terms of the formulation and implementation of national health strategies.

demand for health care. In the meantime, primary health care has been regarded to be the first and basic measure in the planning of an effective health system and the minimum level of state protection, irrespective of the state economic status (see Part I, section 3.4).[33] In Greece, primary health care was first established between the years 1983 and 1989, as part of the introduction of the Greek national health system (ESY). Law 1397/1983 constituted the institutional base of primary health care in the country. In fact, the Greek State aimed at introducing primary health care in line with the principles embedded in Alma-Ata Declaration (see Part I, section 2.2.3), reflecting the importance of primary health care, in that: 'Primary health care is essential health care … It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals … with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process'.[34] Therefore, the Greek State tended to design a primary health care infrastructure based on the principles of equity and participation, being delivered primarily through health centers, urban and rural, which would provide preventive care, palliative care and rehabilitation services. Instead, since 2014 health centers, which play a prominent role in the provision of primary health care in the country, were established only in rural and semi-urban areas, providing a restricted number of activities within health care process. At the same time, we should keep in mind for the purposes of our analysis that primary health care, as part of the ESY, coexists with private for-profit providers of primary health care under Law 2071/1992 (see also section 6.5.1).[35]

Meanwhile, in recent years it appears that there was a growing need for prioritization of primary health care within the ESY. In February 2014, the Greek State, under the financial pressure involved in providing universal health coverage and the increasing costs associated with secondary health care, placed greater emphasis on primary health care. Accordingly, a Primary National Health Network (PEDY) was established by Law 4238/2014.[36] Under this new system, each

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[33] UN CESCR, General Comment No. 3: *The Nature of State Parties' Obligations*, UN Doc. E/1991/23, 14 December 1990, § 10; UN, *The Realization of Economic, Social and Cultural Rights: Report of the Special Rapporteur, Danilo Türk, UN ESCOR, Commission on Human Rights, 43rd Sess., Agenda Item 8*, UN Doc. E/CN.4/Sub.2/1991/17, 18 July 1991, § 52(d).

[34] Declaration of Alma Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, § VI.

[35] Ibidem supra note 26.

[36] Law 4238/2014, *Official Government Gazette* – ΦΕΚ issue Α΄ 38/17-02-2014.

individual, regardless of his/her financial, social and insurance status, including uninsured persons, can equally receive primary health care, while no user fees will be charged until its structure and provided health care services will be fully developed and become operational.[37] Additionally, pursuant to Article 1 § 5 of Law 4238/2014 the provided health care within this new system includes, *inter alia,* prevention and immunization programmes, health promotion, primary mental health care, rehabilitation care, family planning, maternal and child care. At the same time, it seems that this list reflects several of the elements which are included in the list of minimum core obligations defined by the CESCR in its GC No. 14 on the right to health (see Part I, section 3.4).

However, this elaborate enumeration of the specific activities to be provided under the new primary health care system coupled with the five-year economic dysfunction and recession may undermine the potential for engagement by the Greek State, even with the best of intentions by the State. In fact, the CESCR in its 2015 concluding observations urged Greece to enhance the infrastructure of primary health care system.[38] All in all, at this primary stage, it is difficult to assess the new system's effectiveness and impact on the general population's health. Nevertheless, such an approach is not applicable to the general functioning of ESY, whose performance as well as key issues surrounding compliance with the right to health framework by the Greek State will be subsequently considered in section 6.4.

6.4. THE ESY IN RELATION TO THE 'AAAQ'

As a framework for measuring the compliance of Greece's ESY with the right to health, we will use GC No. 14 of the UN CESCR and, particularly, four interrelated and essential elements of the right to health, *Availability, Accessibility, Acceptability and Quality* (the so- called '*AAAQ*') (see Part I, section 3.5).[39] As such, these four principles which constitute the practical framework of the right to health will be applied in the following analysis and areas of concern and future steps will be highlighted. Before embarking on our analysis it must be noted that albeit the ESY was not designed in light of human rights law, it is nonetheless assessed whether this health system is in compliance with this human rights framework.

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[37] Ibid., Article 1 § 3; Greek Ministry of Health, Circular Y3/G.P./oik.23726/17-03-2014, § 2 on Implementation Process of Law 4238/2014 – 'Clarifications for the functioning of the Health Units of the PEDY'.

[38] UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 36(d).

[39] Ibidem supra note 5, GC No. 14, § 12.

In general, Greece spent 9.3 percent of its GDP on health care in 2012, equal to the OECD average and down from a high of 10 percent of GDP in 2009 as well as lower compared to other European countries, including Netherlands, France and Germany (all allocating to health over 11 percent of GDP). Notably, the decline of health expenditures is due to Greece's efforts to reduce the budgetary deficit pursuant to the European Commission's, the European Central Bank's and the International Monetary Fund's (collectively known as the Troika and/or the three Institutions, henceforth: the Troika) economic adjustment programme. As to health status, life expectancy at birth in Greece was at 80.7 years in 2012, almost a year higher than the OECD average (80.1). However, life expectancy in Greece remains lower than in several OECD countries (such as Switzerland, Italy, Spain, France, Iceland and Japan), where life expectancy exceeds 82 years.[40] The aforementioned indicators, which will be addressed below in detail, reflect in principle a national commitment to health (care) for every individual and for the population as a whole.

6.4.1. AVAILABILITY OF HEALTH CARE

With regard to *availability*, it has been indicated that sufficient functioning public health and health-care facilities, goods and services as well as programmes must be provided for the whole population given the State's development level (see Part I, section 3.5).[41] Generally, the ESY fulfills partially this requirement, as primary, secondary and tertiary health care is available through a number of general health facilities together, though, with several structural weaknesses.

Certain shortfalls have been detected during the years of the ESY functioning, especially during 2010-2015 years when Greece was hit by the economic crisis, which had an adverse impact on the availability of health care in Greece. Particularly, for specialized treatments, such as cancer treatments, there are long waiting lists within the ESY. These lists are created due to a restricted number of specialist health facilities coupled with a shortage of medical personnel and a lack of financial resources to make the system more effective. It is worth mentioning that there are solely four specialized oncology public hospitals, namely three oncology hospitals in Attiki (southern Greece) and one oncology hospital in Thessaloniki (northern Greece), providing their specialized health care to the general population in Greece.[42] Consequently, this restricted number of specialist

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[40] Organization for Economic Cooperation and Development, *OECD Health Statistics 2014*, Paris: OECD <www.oecd.org/health/healthdata>.

[41] Ibidem supra note 5, GC No.14, §12(a).

[42] See, Greek Ministry of Health, homepage <http://www.moh.gov.gr>; For instance, there are waiting lists for cancer treatment for about six-eight months.

health facilities mainly combined with the lack of medical personnel contributes to the creation of long waiting lists at the expense of the patients' well-being.

In fact, the situation with regard to the length of the waiting lists for hospital treatment has been exacerbated by the increasing demand for public health care, which in turn is caused by the inability of individuals to afford private health care since the emergence of the economic crisis in Greece. In fact, there was an increase in admissions to public hospitals of 24 percent in 2010 compared with 2009 and of 6 percent in 2011 compared with 2010.[43] Meanwhile, the length of the waiting lists, which are increasingly common, has led a number of people, who can afford to pay for their own care, to seek medical treatment either in the private health sector or abroad. For instance, the number of people in a waiting list for an orthopedics' operation was estimated over 2,000 at a public hospital in Athens (i.e. Tzaneio).[44]

Additionally, the availability of health care, including medical personnel and medical equipment, is crucial in rural and remote areas of Greece, which gives rise to the added problem of disparities in physical accessibility. Apparently, there is a lack of health care in rural and remote areas in Greece, due to the inexistence of competitive salaries for medical personnel and occasional shortages of medical equipment and medicines.[45] At the same time, an over-supply of doctors (working mainly in urban areas) coexists with an under-supply of nurses in Greece, resulting in an inefficient allocation of human resources. Particularly, the number of doctors

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[43] Greek Ministry of Health –Secretary General, *Report on Results of the Ministry of Health and of ESY Units 2011*, Athens: Dionikos publications 2012, p. 24.

[44] Analytical Support on Socio-Economic Impact of Social Protection Reforms (ASISP), *Annual National Report 2011: Pensions, Health Care and Long-term Care. Greece,* Brussels: European Commission, DG Employment, Social Affairs and Inclusion, May 2011, p. 18; See, also, 'Blocking in public hospitals: Waiting time up to 6 months for an examination' *Ethnos newspaper* (in greek) (14 April, 2014); For the management of waiting lists see, Council of Europe Committee of Ministers Recommendation No. R (99) 21 on criteria for the management of waiting lists and waiting times in health care, September 1999.

[45] I. Tsiligianni, F. Anastasiou, M. Antonopoulou et al, on behalf of the Cretan Practice based Primary Care Research Network 'G. Lambrakis', the Clinic of Social and Family Medicine, and School of Medicine, University of Crete. 'Greek rural GPs' opinions on how financial crisis influences health, quality of care and health equity' Letter to the Editor. *Rural Remote Health* 2013, 13: 2528; Greek Ministry of Health, *ESYnet, Functional Data of Hospitals*, November 2011; For instance, in February 2013 pharmaceutical companies have decreased supplies at hospitals and pharmacies due to unpaid bills and low profits, see, e.g., Sukkar E, Smith H. "Panic in Greek pharmacies as hundreds of medicines run short" *The Guardian* (27 February, 2013) <http://www.guardian.co.uk/world/2013/ feb/27/greece-blames-drug-companies-shortages>.

per capita increased up to 2008 and reached 6.2 physicians per 1000 population in 2011, nearly twice as much the OECD average of 3.2. On the other hand, there were only 3.3 nurses per 1000 population in 2009, a much lower figure than the OECD average of 8.8.[46] On this issue, the CRC Committee in its report has recommended Greece '… to strengthen its health infrastructure, including through the recruitment of additional nurses and social workers'.[47]

Meanwhile, at the Council of Europe (CoE) level, the European Committee of Social Rights (ECSR) set out in its 'conclusions' for Greece a number of health indicators, in order to evaluate the availability of health care in Greece and ultimately to measure Greece's compliance with its obligations under the right to health embedded, *inter alia*, in Article 11 of the European Social Charter (ESC) (see Part I, section 3.6).[48] More specifically, in Greece the average life expectancy at birth in 2011 was 78.5 for men and 83.1 for women. In 2011 life expectancy was close to the EU average, namely higher for men and equal for women, whereas EU average in 2004 was 75.2 for men and 81.5 for women. Generally, the mortality rate in 2011 was 98.3 per 10.00 inhabitants, while the EU average in 2011 was 111.2 per 10.00 inhabitants. Additionally, the infant mortality rate amounted in 2008 to 26.5 deaths per 10.00 live births and increased in 2011 to 33.5, while the EU rate in 2011 was 57.6 per 10.00. As such, the infant mortality rate despite its increase in 2011 still remained lower compared to the EU rate. With respect to the maternal mortality rate, the ECSR notes that it amounted to 3.76 deaths per 100.000 live births in 2011, which is one of the lowest rates in Europe. In fact, the EU rate was 8.42 per 100.000 live births in 2011.[49]

Additionally, as to the assessment of health care facilities, the average numbers of hospital and psychiatric beds were 591 and 600 per 100000 inhabitants in Europe for 2005 respectively.[50] In Greece, the numbers of hospital and psychiatric beds were 470 and 860 per 100000 inhabitants for 2005 respectively. Moreover, in Greece,

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46 Organization for Economic Cooperation and Development, *OECD Health Statistics 2014*, Paris: OECD <www.oecd.org/health/healthdata>.

47 Ibidem supra note 30, UN CRC Committee, § 53.

48 The ECSR examines states' reports and decides whether or not the situations (national law and practice) in the states concerned are in conformity with the European Social Charter (ESC) (Revised). Its decisions are known as 'conclusions'. ; European Social Charter, 18 October 1961, entered into force 26 February 1965, ETS 35; ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010; ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, November 2014. Note that the ECSR uses as benchmark the average of all EU countries concerning the indicators applied in its 'conclusions' for Greece.

49 Ibid.

50 Ibid.

with regard to physicians, there were 56310 physicians, equating to 50 physicians per 10000 habitants. Pursuant to the aforementioned figures, the density of health care professionals is comparable to that observed in other European countries and the quantities of health care facilities are considered to be sufficient compared to the EU average. In fact, with respect to the resources spent on health care, the ECSR in its Conclusions enlisted Greece among the countries allocating the highest proportions to health care in Europe in 2006, namely 9.9 percent of GDP.[51] Moreover, with regard to the management of waiting lists for hospital treatment, the ECSR requested Greece to provide additional information on the regulation of access to health care, as there was an evident lack of such information from the part of Greek authorities.[52] At this point, it is noteworthy that the aforementioned health indicators, such as life expectancy, rates of mortality and waiting lists raise also matters of accessibility and quality of health care services (see section 6.4.3).

Nonetheless, mainly since 2010, the Greek Ministry of Health has implemented a number of severe austerity and structural health reform measures as a condition of its 2010 and 2012 loan agreements with the Troika: that public health expenditures must not exceed 6 percent of the GDP; and hospital costs are expected to be reduced by at least 10 percent in 2011 and by an additional 5 percent in 2012 in addition to the previous year.[53] As such, the Greek State faced dramatic reductions in health spending from 2010 onwards, namely four consecutive falls in per capita health spending (10.9 percent for 2009/10, 2.8 percent for 2010/11, 12.2 percent for 2011/12 and 2.5 percent for 2012/13).[54] To implement these stringent reductions, the reform measures taken by the Greek State include, *inter alia*, the merger of public health-care facilities (clinics) –hospitals, rehabilitation care units for persons with disabilities etc., the reduction of hospital budgets and of pharmaceutical expenses.[55] Accordingly, the number of medical institutions providing inpatient

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51 Ibid.

52 Ibid.

53 International Monetary Fund, *Greece: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding*, International Monetary Fund, 8 December 2010; Law 3845/2010, *Official Government Gazette* - ΦΕΚ issue Α′ 65/06-05-2010; Law 4046/2012, *Official Government Gazette* - ΦΕΚ issue Α′ 28/14-02-2012; ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, November 2014, p. 16; European Commission, *The Second Economic Adjustment Programme for Greece,* European Economy - occasional papers No.94, Brussels: European Commission March 2012, p. 63.

54 OECD, *Focus on Health Spending- OECD Health Statistics 2015*, July 2015, p. 4.

55 European Commission, *The Economic Adjustment Programme for Greece, Fourth Review - Spring 2011*. Brussels: European Commission, 2011; For more details on the merger of

health care was reduced from 138 in 2010 to 81 in 2011.[56] Additionally, since 2011 there has been an increasing concern at whether a number of prevention programmes for unsafe and illicit drug use, involving injecting drug users (IDUs), could effectively operate due to the on-going reduction of human and financial resources.[57] As a consequence, the number of new HIV infections among IDUs increased from 15 in 2009 to 484 in 2012[58], while tuberculosis among IDUs significantly rose from 5-12 in 2007-2012 (annual incidents) to 24 in 2013, namely doubled compared to past figures.[59] These figures identify an apparent inadequacy of targeted preventive programmes to deal with drug addictions, such as the availability of essential services, involving needle and syringe distribution programmes, distribution of condoms and opioid substitution treatment.[60] As such, there is an urgent need to strengthen preventive care and treatment through an effective allocation of and utilization of available human and financial resources, and a design of appropriate measures to address the health needs of this vulnerable population group on the part of the Greek State (see Part I, section 4.2).

In light of the above, the decrease in public health expenditures and hospital costs has, unavoidably, a direct impact on the level of fulfillment of the State's obligation to provide health care under the right to health and consequently raises great concern under the principle of 'availability' of health care services. As such, it can be maintained that the prevailing national policies (e.g. the lack prioritization

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public health facilities see Article 1 of Law 4025/2011, *Official Government Gazette*- ΦΕΚ issue Α′ 228/02-11-2011 – merger of rehabilitation care units- and Article 1 of Ministerial Decision Υ4α/ΟΙΚ. 122826*, Official Government Gazette* - ΦΕΚ issue Β′ 2674/09-11-2011; Law 4127/2013, *Official Government Gazette* - ΦΕΚ issue Α′ 50/28-02-2013 on hospital budgets, involving pharmaceutical expenses.

56 Ibid.

57 Greek Documentation and Monitoring Centre for Drugs (EKTEPN), *Annual Report on the State of the Problem of Drugs and Alcohol in Greece 2011*, Athens: Research University Institute on Mental Hygiene 2011, pp. 9 and 227; European Centre for Disease and Control, *Joint technical mission: HIV in Greece 28-29 May 2012*, Stockholm: ECDC 2013, p. 18; Such concerns are also expressed by the CESCR, while at the same time noting the increase in the number of HIV infections among injecting drug users, see UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 37.

58 European Centre for Disease Prevention and Control/ WHO Regional Office for Europe, *HIV/AIDS Surveillance in Europe 2012,* Stockholm: European Centre for Disease Prevention and Control 2013, p.29; Ibid., UN CESCR, § 37.

59 G. Spala, *Epidemiological Data for Tuberculosis in Greece*, Athens: Hellenic Centre for Disease Control and Prevention (KEELPNO) 2013.

60 Ibidem supra note 57, ECDC 2013, p. 19; Ibidem supra note 57, UN CESCR, UN Doc. E/C.12/GRC/CO/2, § 38.

of the most pressing health problems of vulnerable groups) implicate a violation of the obligation to secure availability of health facilities, goods, services and programmes pursuant to the right to health, if not justifiable by the Greek State on the basis of allocation of its available (limited) resources. This implies that the Greek State must demonstrate that it has endeavored to fulfil its right to health obligations in light of its available (limited) resources (see Part I, section 4.2).

6.4.2. ACCESSIBILITY OF HEALTH CARE

As observed in Part I (see section 3.5), accessibility encompasses four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and access to information, within which explicit reference is made to ensure access to vulnerable and marginalized sections of the population.[61]

6.4.2.1. Non-discrimination

The non-discrimination dimension in accessibility requires health facilities, goods and services be accessible to everyone without discrimination.[62] As such, the non-discrimination dimension is significant to ensuring that the health system is responsive to the needs of all its recipients. In Greece, vulnerable groups in principle have been given extra attention in the provision of health care.[63] Pursuant to Article 1 § 2 of Law 1397/1983, the Greek State is under the obligation to provide healthcare equally to all citizens, irrespective of their financial, social and employment status.[64] In addition, Law 3304/2005 highlights the right to equal treatment of every individual and prohibits any discrimination on the grounds of ethnic, national or racial origin, religious or other beliefs, disability, age or sexual orientation, which has the intention or effect of nullifying or impairing social protection, including access to health care.[65]

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[61] Ibidem supra note 5, GC No. 14, § 12(b).

[62] Ibidem supra note 5, GC No. 14, § 12(b).

[63] Vulnerability is shaped by many factors, such as age, dependency, lack of socio-economic resources, ethnic origin, social, economic or political marginalization, lack of legal status and is connected to the prospects of individuals for enjoyment of the right to health in this particular case (see Part I, section 4.2.3).

[64] Ibidem supra note 10, Law 1397/1983.

[65] Law 3304/2005 on the 'Implementation of the principle of equal treatment, irrespective of race, nationality, religious or other beliefs, disability, age or sexual orientation' has integrated at the national level the Council Directive 2000/43/EC of 29 June 2000 which refers to health care.

Pursuant to the respective law provisions, the distribution of health care cannot be based on discriminatory grounds, such as the ability of individuals to pay, social or national origin, which could have otherwise led to a denial of health care to certain groups of the population (see sections 7.3 and 8.3). In essence, the ESY cannot deny access to health care for any person in serious medical need such as uninsured people, homeless people who are unable to pay for their treatment. Such vulnerable groups mainly emerged as a result of the financial crisis in Greece. Meanwhile, increased irregular migration coupled with the rising and hardly manageable costs of health care has led the Greek State to adopt a law that restricts the accessibility of health care to a certain population group, namely undocumented migrants (see section 7.3.3). The respective Law, though, recognizes an exception to the extent of treatment as to undocumented migrant children and undocumented migrant pregnant women, albeit at a relatively abstract level (see sections 7.3.3 and 7.3.4).[66]

6.4.2.2. Physical accessibility

In addition to non-discrimination, the Greek State is also required to secure that health care is physically accessible for all sections of the population.[67] For that purpose, it is significant that primary health care is delivered through local health centers/mobile units in order to secure the accessibility for vulnerable groups from remote-rural areas, such as Roma children (see chapter 8). At the same time, especially in case of the population groups requiring special attention (e.g., persons with disabilities) adequate access to health facilities-buildings should be provided in light of this principle.[68] Admittedly, a critical concern is the existence of appropriate and upgraded infrastructure which will meet their needs and enable their access, such as provision of curb cuts (ramps), lifts etc. In this spirit, Greece introduced Law 3230/2004, which provides under Article 12 § 10 that public services are under the obligation to take all the necessary measures with a view to ensuring accessibility of persons with disability to public areas, including health facilities. By choosing to implement the above mentioned legislation, Greece has

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66 Article 84 of Law 3386/2005, *Official Government Gazette* - ΦΕΚ issue Α΄ 212/ 23-08-2005, replaced by Article 26(2)(a) of Law 4251/2014, *Official Government Gazette* - ΦΕΚ issue Α΄ 80/01-04-2014.

67 Ibidem supra note 5, GC No.14, § 12(b).

68 Ibid; Article 25(c) of the Convention on the Rights of Persons with Disabilities (CRPD), 30 March 2007, entered into force 3 May 2008, UN Doc. A/RES/61/106 (Note that here physical accessibility is considered within its actual meaning); See also Annex 2.

tended to take account of every individual's needs regarding the physical accessibility of public areas, such as public health facilities (public hospitals).[69]

Meanwhile, in the Conclusions of the ECSR for Greece, much attention is paid to the geographical distribution of health care, which is largely connected to the nature of the Greek geography (i.e. 80 percent of Greece is mountainous and 227 islands in the Aegean, Ionian and Mediterranean seas are inhabited). Given the size and geography of the country, the ECSR in its conclusions expressed its concern about the accessibility of health care facilities in remote, rural areas.[70] Particularly, in Greece there are significant disparities between urban and remote, rural areas in the provision of health care, including the geographical distribution of health personnel and health facilities. At the same time, these inequalities are often connected to inequalities in access to health care for less developed regions or persons belonging to racial/ethnic minority groups within the population, such as the Roma children. Consequently, this state practice may hamper the physical accessibility of health care and can lead to discrimination (even if not overtly) in access to health care, when considering the health status and health care needs, as previously indicated in section 6.4.2.1.

Another critical issue which constitutes a source for concern in light of physical accessibility is the merging of hospitals and rehabilitation care units, as earlier observed, in that patients are required to travel more than before for receiving the necessary care.[71] Note that, recently (2014), the Greek State introduced a new Law on developing a local network of services in order to facilitate access to primary health care, as observed earlier (see section 6.3).[72] Furthermore, with regard to the Roma children and their families, the Greek State established around 30 Centers (former Medico-Social Centers) in their organized settlements, providing preventive and basic health care, in order to cope with the significant disparities in physical access to health care (albeit a temporary measure whose future function is questionable) (see section 8.3.3).[73]

6.4.2.3. Economic accessibility

The issue of economic accessibility (affordability) is also of high importance, as

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[69] Notably, this requirement is also included in the CRPD, which Greece has ratified and incorporated by Law 4074/2012, *Official Government Gazette* - ΦΕΚ issue Α′ 88/11-04-2012.

[70] ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

[71] Ibidem supra note 55.

[72] Law 4238/2014, *Official Government Gazette* – ΦΕΚ issue Α′ 38/17-02-2014.

[73] Ibidem supra note 70, p. 11.

health care, including services and drugs, must be affordable to all.[74] This implies that health expenses should not burden excessively individuals, in that access to health care should not be dependent on an individual's ability to pay, but only on medical criteria (i.e., care necessitated by an individual's health condition).[75] In line with the aforementioned, under its founding Law 1397/1983, the ESY does not deny emergency treatment to people without health insurance or unable to pay user fees.[76] At the same time, no legislative provision provides clarity with regard to the vague concept of the term 'emergency' and, thereby, health professionals are left to decide on this issue, namely on a case-by-case basis.[77]

Notably, in September 2013 a health voucher programme financed from European Union structural funds came into effect to cover 230,000 individuals without health insurance for 2013–2014.[78] More specifically, this temporary programme was addressed to individuals who had lost their access to health care due to their unemployment and economic status. The health voucher was used for up to three visits by covering a predetermined package of primary care services during an eight month period and prenatal examinations for pregnant women during a four month period. A critical concern was that this programme offered a narrow basic health care package for a certain period of time and it did not apply to additional health care coverage, as a result patients with more medical needs, such as patients with chronic diseases, pregnant women (need to have access to pre- and post-natal care), were refused in practice added coverage. In essence, this state practice was particularly detrimental to uninsured people with chronic diseases who need supplementary health care and, consequently, it affected the affordability of health care for those persons.

Subsequently, given the serious and extensive consequences of the economic recession on many segments of the population in 2014 the Greek State issued two decisions for cost-free access to hospital and pharmaceutical care for individuals

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74 Ibidem supra note 5, GC No. 14, § 12(b).

75 Ibid.; UN CESCR, *Guidelines on Treaty-Specific Documents to be submitted by the States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/C.12/2008/2, 24 March 2009, Annex, § 56(b) and 57(f); See also, Article 13(1) (Revised) ESC.

76 Ibidem supra note 10, Article 1(2).

77 For a definition of the term 'emergency' within Greek case law, see, *inter alia*: Council of State Decisions 632/1999, 866/1997, 5421/1995 and Administrative Court of Athens Decision 4494/2002. Pursuant to the aforementioned court decisions, emergency is defined as a life threatening situation.

78 Greek Ministry of Health, *Health Voucher Programme*, Ministry of Health 2013. <http://www.healthvoucher.gr> (in Greek).

and their family members who have lost their insurance coverage and can no longer afford such coverage. Nonetheless, this measure provides for a complex supervisory procedure -exercised by a number of public authorities at different levels- without covering outpatient laboratory tests, as a result it is difficult to foresee the extent to which individuals can ultimately gain access to such care.[79]

In essence, the ESY cannot be considered economically accessible due to the state practice to require user fees for the provision of publicly funded (mainly funded by the tax system) health care, even before the crisis in 2010.[80] In 2011, though, there was an increase of such user fees and co-payments, i.e., from 3€ to 5€ with regard to regular outpatient visits in ESY (with some exceptions for vulnerable groups, such as patients with chronic diseases, persons with disabilities etc., and for emergency treatment) and in 2014 around 15% and more rise as to the co-payments by the insured for certain medicines.[81] Furthermore, in January 2014 a new user fee per prescription, namely 1€ per prescription, was introduced with some exceptions for vulnerable groups, such as patients with chronic diseases, regulated by respective decisions of the Greek Minister of Health.[82] Moreover, an additional user fee of 25€, namely for inpatient admission to public hospitals, was established to be in effect from January 2014, but the respective legislative provision was never implemented and was ultimately withdrawn due to excessive pressure exerted from the Greek parliament (i.e. the majority of political parties), prominent medical associations and from society in general.[83]

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79 Joint Ministerial Decision Y4a/GP/oik.48985/2014 'Defining the Conditions, Criteria and Process of Access to Health Care for the Uninsured and Financially Weak people', *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1465/05-06-2014; Joint Ministerial Decision G.P./oik56432/28-06-2014, 'Defining the Conditions, Criteria and Process concerning Access to Pharmaceutical Care for Uninsured and Financially Weak People', *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1753/28-06-2014.

80 Joint Ministerial Decisions: A3g/oik./7829/F.15, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 514/11-07-1991(introduction of user fees for outpatient services in public hospitals) and Y3a/G.P.oik.88618, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1223/20-09-2002 (introduction of user fees for health services provided in health centers).

81 As to the exceptions introduced see, Circular of the Greek Ministry of Health, Y4a/oik.1329/04-01-2011; As to the high prices in medicines see, Ministerial Decision, oik.38733/29-04-2014, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1144/06-05-2014; Ibidem supra note 55, European Commission 2011; Of note, the 5 € user fee for outpatient visits in ESY was abolished in April 2015 by a Joint Ministerial Decision, A3(g)/GP/oik.23754, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 490/01-04-2015.

82 Article 1(IB.2) (12) of Law 4093/2012, *Official Governnment Gazette*- ΦΕΚ issue Α΄ 222/12-11-2012; Greek Ministry of Health, Circular 863/07-01-2014.

83 Ibid.; See, e.g., 'Strong reactions regarding the 25€ user fee for hospitals' skai.gr news desk

All in all, it must be conceded that the aforementioned measures which mainly came into effect since 2010 have shifted the cost for health care to patients and, thereby, have created economic barriers in access to the national health system in Greece for several segments of the population. As a result, there is a risk that the poorer segments of the society will forgo from seeking medical treatment due to the high user fees in health care delivery.[84] It is notable that the cost of health care in Greece places an excessive financial burden on individuals, especially on poorer households, as access to health care is eventually not based on medical need, but rather on the ability to pay. Indeed, when looking from the perspective of the human rights principle of economic accessibility, the Greek health system cannot be said to promote the effective enjoyment of the right to health (care), as access to this system is beyond the financial means of the majority of the general population. It is on this basis that the CRC Committee in its concluding observations for Greece underlined that 'the right to health and access to health services are not respected for all children'.[85] In fact, the Committee voiced its concern as to the economic accessibility of health care services especially for vulnerable groups of children, such as Roma children, migrant, asylum-seeking and unaccompanied children.[86]

Thereto, in order to comply with its obligation to secure economic accessibility under the right to health, the Greek State must take concrete measures to reduce the excessive financial burden (i.e. to adopt low-cost targeted programmes) on patients belonging to the most vulnerable and socially disadvantaged sections of the population, such as low-income individuals, patients with chronic diseases, children, and women, and ensure that health care remains affordable.[87] To this aim, the cost of health care (i.e. the co-payments) should be borne, at least in part, by the population as a whole with special attention to vulnerable groups, in order medical protection not to become too expensive, affecting equal accessibility to health care.[88]

(02-01-2014) available at <www.skai.gr/news/health/article/2490897/edones-adidraseis-gia-to-eisitirio-ton-25-euro-sta-nosokomeia>

84 UN, *The Realization of Economic, Social and Cultural Rights: Report of the Special Rapporteur, Danilo Türk, UN ESCOR, Commission on Human Rights, 44th Sess., Agenda Item 8*, UN Doc E/CN.4/Sub.2/1992/16, 3 July 1992, § 102.

85 Ibidem supra note 30, UN CRC Committee 2012, § 52.

86 Ibid.

87 See, also, The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC, March 2009, pp. 9-10; Ibidem supra note 33, GC No. 3, § 12.

88 Ibid.; See, e.g., Ibidem supra note 33, UN Doc. E/CN.4/Sub.2/1991/17, § 52(c); Recommendation 1626 (2003) of the Parliamentary Assembly of the Council of Europe on 'the reform of health care systems in Europe: reconciling equity, quality and efficiency', § 5.

6.4.2.4. Access to information

Accessibility also includes the right to seek, receive and impart information on health issues, however not at the expense of the right to privacy which requires confidentiality in all health-related matters.[89] This implies that individuals have a right to be informed about health issues as well as in terms of prevention, treatment and control of epidemic, endemic and other diseases. States are consequently required to design and adopt prevention and education health-related programmes.[90] Generally speaking, information accessibility is almost adequate in Greece, as will be subsequently analysed.[91] Importantly, Article 3 § 2(c) of Law 2519/1997 provides that the public health services under the auspices of the Greek Ministry of Health are responsible for the design and implementation of health education programmes in collaboration with local authorities.[92] Such programmes involve, *inter alia*, the distribution of information material to schools, local communities and at high risk groups and aim to promote health education and raise awareness in society about health-related issues, such as voluntary blood donation, the advantages of breastfeeding, children vaccinations, oral health, diabetes mellitus and smoking, in which knowledge and education must be provided to the general population.

Another critical issue of information accessibility is that the State has an obligation to provide adequate information regarding situations that may endanger general population's health, such as in case of an infectious disease. In 1992, Greece introduced the Hellenic Centre for Disease Control and Prevention (HCDCP-abbreviated in Greek as KEELPNO, former KEEL) under the auspices of the Greek Ministry of Health. Particularly, KEELPNO is responsible for the prevention and control of infectious and chronic diseases through collecting and providing data (Article 26 of Law 2071/1992, PD 358/1992 and Article 20 of Law 3370/2005).[93] Additionally, under respective law provisions KEELPNO has an obligation to

[89] Ibidem supra note 5, GC No. 14, § 12(b).

[90] Ibidem supra note 5, GC No. 14, § 16.

[91] See, ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, November 2014, p. 16.

[92] Law 2519/1997, 'Development and modernization of the National Health System, organization of the public health services and other provisions', *Official Government Gazette* - ΦΕΚ issue Α΄165/21-08-1997.

[93] Ibidem supra note 26, Law 2071/1992 and Law 3370/2005 'Organization and Functioning of Public Health Services and other provisions' – reorganization of the Hellenic Centre for Infectious Diseases Control- *Official Government Gazette* - ΦΕΚ issue Α΄ 176/11-07-2005. The function and the responsibilities of the organization were regulated by the PD 358/1992, *Official Government Gazette* - ΦΕΚ issue Α΄179/24-11-1992.

organize and implement information campaigns related to Sexually Transmitted Diseases and AIDS as well as to inform the population about several other health issues, including public health promotion and protection, disease prevention, environmental health threats, epidemics etc.[94] Notwithstanding the above, there are striking examples of existing failures in the implementation of the law regulating various features of access to health information. For instance, the CESCR in its 2015 report noted with concern the increase in the number of HIV infections in Greece linked to the need for enhancement of the national preventive strategy, involving awareness-raising activities, and for the provision of adequate funding for such activities.[95] Such observations demonstrate an implementation gap between law and everyday practice on the part of the Greek State concerning the formulation and implementation of comprehensive information raising activities.

Meanwhile, in addition to the promotion of health education and information campaigns, patients are also entitled to get informed about their health status and possible medical treatments by health professionals, while at the same time medical confidentiality is required to be safeguarded. In fact, Article 47 of Law 2071/1992 generally provides for the protection of hospital patients' rights.[96] Accordingly, Article 47 §§ 4 and 5 emphasizes, *inter alia*, that patients (or their legal representatives) have the right to request information concerning their medical situation, which should be comprehensive in order to obtain a complete picture of the medical, social and financial parameters of the proposed treatment plan and participate in the decision-making process.

Likewise, it should be stressed that the Greek State has issued a Law on medical ethics, Law 3418/2005.[97] When it comes to medical interventions, Article 11 of Law 3418/2005 underlines the physician's legal/professional duty to inform the patient about his/her medical condition; the involved health risks; the effectiveness of the proposed treatment plan; and alternative options of treatment in order to take well-informed decisions.[98] In fact, this obligation had been already

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[94] Ibid.; Article 20 of Law 2889/2001 'Improvement and Modernization of the National Health System and other provisions', *Official Government Gazette* - ΦΕΚ issue Α′ 37/02-03-2001 – Prevention of biological and toxic threats- and Article 44 of Law 3204/2003, *Official Government Gazette* - ΦΕΚ issue Α′ 296/23-12-2003 – Data Collection on infectious diseases and Intervention with mobile units for the promotion and protection of public health.

[95] Ibidem supra note 57, UN CESCR, UN Doc. E/C.12/GRC/CO/2, § 38.

[96] Ibidem supra note 26.

[97] It is noteworthy that Law 3418/2005 amended the 1955 Regulation on Medical Deontology and that the 1939 Code on the practice of Medicine remains valid.

[98] Law 3418/2005 'Code of Medical Deontology', *Official Government Gazette* - ΦΕΚ issue Α′ 287/28-11-2005.

established by Law 2619/1998 (Article 5), by which the Biomedicine Convention was incorporated at the national level. Meanwhile, the application of a medical treatment without the prior information of the patient and, thereby, informed consent of the patient (the patient's authorization/ agreement concerning a specific medical treatment) was found by a Greek court to be arbitrary and unlawful, even though the applied treatment was found to be in accordance with the rules of medicine.[99]

6.4.3. ACCEPTABILITY AND QUALITY OF HEALTH CARE

With respect to *acceptability*, it has been underpinned that all health facilities, good and services must be, *inter alia*, respectful of medical ethics and culturally appropriate in addition to gender and life-cycle sensitivity, as well as being designed to respect and protect confidentiality, and improve the health status of those served (Part I, section 3.5).[100] In terms of acceptability, Greece has a long history of requiring its health professionals to adhere to minimum ethical/professional guidelines, involving being respectful of the culture of individuals, minorities and communities. This implies that the varying cultural backgrounds of patients may have to be respected, such as the refusal of a blood transfusion by Jehovah's witnesses, the use of alternative forms of treatment, traditional preventive care, healing practices and medicines by indigenous people.[101] In this regard, the ECtHR has acknowledged that 'the freedom to accept or refuse specific medical treatment, or to select an alternative form of treatment, is vital to the principles of self-determination and personal autonomy. A competent adult patient is free to decide, for instance, whether or not to undergo surgery or treatment or, by the same token, to have a blood transfusion. For this freedom to be meaningful, patients must have the right to make choices that accord with their own views and values, regardless how irrational, unwise or imprudent such choices may appear to others'.[102] The Court, though, further noted that only in case of an indication regarding the need to protect third parties (e.g., mandatory vaccination during an epidemic to prevent the spread of contagious diseases) interference with this freedom is justified.[103]

Meanwhile, primarily under the Code of Health Deontology, Law 3418/2005, the medical profession in Greece is legally bound to serve every individual without

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99 Court of Appeal of Athens 5512/2003, *EllDik* 2004, 45, pp. 197-198 (also available: <www.lawdb. intrasoftnet.com>.

100 Ibidem supra note 5, GC No. 14, § 12 (c).

101 Ibid., § 27

102 *Jehovah's Witnesses of Moscow and others v. Russia* (Application no. 302/02), ECtHR 10 June 2010, § 136.

103 Ibid.

discrimination and meet appropriate standards of skills and (ethical) codes of conduct.[104] Although there might be incidents of individual practitioners who may violate these legal/professional requirements (see section 6.5.2), the vast majority of medical profession upholds high ethical standards and is committed to abstain from unethical and unprofessional behavior. The relationship between a patient and a doctor is critical for the effective health care provision and, thereby, it requires a certain level of trust and communication. Accordingly, Article 47 § 7 of Law 2071/1992, which provides for the protection of hospital patients' rights, stresses that religious beliefs of patients should be respected by the physicians, such as the beliefs of Jehovah's witnesses.[105] Similarly, the nursing personnel is legally bound to care for every individual without discrimination of any kind, regardless of race, national or social origin, religious beliefs or other status, under the Code of Nursing Deontology, PD 216/2001.[106]

Nonetheless, particular concern arose in Greece regarding the medical treatment of migrants, especially undocumented migrants, and the enforcement of a discriminatory practice under Article 54 § 2 of Law 2910/2001.[107] Article 54 § 2 of Law 2910/2001 provided that persons, working, *inter alia,* in the health care sector, were required, under the threat of sanctions, to report the presence of any undocumented migrant, encountered in the course of their work, to police authorities or to immigration officials. However, such a provision justified actions that not only undermined the right of every individual to health (care), but also threatened the medical professionalism of health care providers due to the processing of sensitive personal data without the individual's explicit consent. In particular, the disclosure of information was found to be in conflict with an individual's right to health as well as to constitute an infringement of a patient's right to privacy and of the health professional's duty to medical confidentiality under Law 3418/2005.[108]

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104 Law 3418/2005 'Code of Health Deontology', *Official Government Gazette* - ΦΕΚ issue Α′ 287/28-11-2005.

105 Ibidem supra note 26.

106 PD 216/2001 'Code of Nursing Deontology', *Official Government Gazette*- ΦΕΚ issue Α′ 167/25-07-2001.

107 Law 2910/2001 on 'Entry and Stay of Foreigners in the Greek territory. Possession of Greek Citizenship and other Provisions', *Official Government Gazette* – ΦΕΚ issue Α′ 91/ 02-05-2001. Article 51 § 1 of Law 2910/2001 granted equal access to social protection and social security as nationals only to migrants with legal presence in Greece.

108 Law 3418/2005 'Code of Health Deontology', *Official Government Gazette*- ΦΕΚ issue Α′ 287/28-11-2005; See also, Advisory no. 86/2001 of the Hellenic Data Protection Authority (HDPA), 19 June 2001, § 7. <http://www.dpa.gr> (last accessed 10 November 2013)

At the same time, such a provision was certainly in conflict with the letter of Article 5 § 5 of the Constitution (see section 5.2.1). Importantly, this provision was not employed for serving a public health aim -as in the case of reporting certain contagious diseases- but for achieving a criminal immigration goal. As such, the tool of reporting served to counteract irregular migration. As a result, this legislative provision -disclosure of personal data- deterred undocumented migrants from seeking medical treatment for themselves or for their family members even in serious cases. In fact, they were afraid of being reported and apprehended while accessing health care, with adverse effects on their health and well-being.[109] Nevertheless, in 2005 the respective law provision was abolished by Law 3386/2005 given the concern about the effective enjoyment of the right to health (care) of every individual and about the processing of sensitive data without the individual's explicit consent for purposes other than medical care.[110] Such a situation clearly demonstrates that the Greek State should systematically review and abandon laws and/or policies that negatively affect the 'acceptability' of health care and raise issues of concern in light of this principle.

All in all, confidentiality is a significant principle within health care settings and is of high importance especially in relation to HIV testing, as a potential breach of confidentiality might deter individuals, including in this particular case undocumented migrants, from seeking HIV testing. The ECtHR in its case law has repeatedly expressed concern about the disclosure of medical data and has paid particular attention to the significance of confidentiality of medical data. Accordingly, the Court has stressed that 'the protection of personal data, in particular medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.'[111] The Court also acknowledged

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[109] Advisory no. 86/2001 of the Hellenic Data Protection Authority (HDPA), 19 June 2001, § 6.

[110] Ibid., Advisory no. 86/2001 of HDPA, §§ 5 & 7-8.; Directive 95/46/EC of the European Parliament and the Council of 24 October 1995 'on the protection of individuals with regard to the processing of personal data and on the free movement of such data'; Ibidem supra note 66, Law 3386/2005 on 'Entry, Residence and Social Integration of Third□Country Nationals in the Greek Territory'. The requirement to report, placed on public officials, was repealed by Law 3386/2005, Article 87(2).

[111] *Z. v. Finland* (Application no. 22009/93), ECtHR 25 February 1997, § 95; See, *inter alia*,

that without such protection, those in need of medical assistance may be deterred from seeking such assistance, thereby endangering not only their own health and but also, in the case of transmissible diseases, the health of the society.[112]

Finally, *quality* is another significant factor in the delivery of health care. It requires that health care is scientifically and medically appropriate and of a good standard. The requirement of quality also extends to the manner in which people are treated by the medical staff and as such cultural acceptability, as earlier elaborated, is an essential element of the quality standard.[113] On the basis of the professional/legal code -Codes of Health and Nursing Deontology (Law 3418/2005 and PD 216/2001, respectively)- the medical profession has legally committed itself to providing good quality health care (see section 6.2.2., *'(v) Members of the Medical Profession'*). Additionally, as mentioned previously, in the context of the CoE, the ECSR has paid attention in its 'conclusions' for Greece to indicators, such as life expectancy, rates of mortality and waiting lists which also raise matters of quality of health care and can serve as indicators of a well-functioning healthcare system in a given country.[114] Accordingly, the health status of the population in Greece was at a relatively good rate until 2008 which may reflect the State's commitment to quality health care. However, a resurgence of infant mortality rates was reported concerning the consecutive years 2009, 2010 and 2011.[115] Such an increase may indicate a decline of the quality of health care related to the Troika's structural adjustment programme (i.e. implementation of a number of austerity measures in the area of health) based on which the Greek State is obliged to restrict public health expenditure. Such disturbing figures in relation to infant mortality rates, which constitute also matter of availability of health care services (see section 6.4.1) raise concern about the availability and quality of pre-natal health care services for pregnant women under the 'AAAQ'. At the same time it must be conceded that infant mortality rates can be affected not only by barriers in access

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L.L. v. France (Application no. 7508/02), ECtHR 10 October 2006, § 44; *I. v. Finland* (Application no. 20511/03), ECtHR 17 July 2008, § 38; *Armoniene v. Lithuania* (Application no. 36919/02), ECtHR 25 November 2008, § 40.

112 *Z. v. Finland* (Application no. 22009/93), ECtHR 25 February 1997, § 95.

113 Ibidem supra note 5, GC No. 14, § 12(d); Ibidem supra note 4, UN Doc. A/HRC/7/11, § 54.

114 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010; Ibidem supra note 44, Council of Europe, Recommendation No. R (99) 21, §§ 3 and 12.

115 Hellenic Statistical Authority, Statistics 2013, Athens: ELSTAT, 2013; See, also, WHO Regional Office for Europe, *European Health for All Database 2013*. <http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db>

to timely and effective health care in pregnancy and early life, but also by worsening socio-economic circumstances and immigration from poor countries, which are also of decisive importance for an individual's health status.[116] Thereto, the Greek State must ensure the best possible state of health for the population and as a result, every step should be taken to secure the quality of health care in Greece, involving the enhancement of socio-economic determinants of health, which constitute human rights concerns (see Part I, section 3.2).

In the meantime, there is a critical concern that due to the State's effort to decrease health care expenditure the ESY will not provide health care that is appropriate (of good quality) for its recipients (see Part I, section 4.2). In fact, the lack of funding has been reported as the main obstacle to higher quality of health care in Greece in a 2012 Eurobarometer qualitative survey.[117] Moreover, the Greek public health sector is characterized by corruption, as will be analysed in section 6.5.2, which hinders the quality of health care. In addition, long waiting lists in the ESY, which are medically unacceptable due to the patient's condition and need, are considered to be a large risk for corruption (perhaps one of the main forms of corruption) given the informal payments to bypass these lists and gain priority in access (section 6.5.2).[118] As noted earlier, long waiting lists is a major quality problem which several patients experience in the ESY. Indeed, a Eurobarometer survey shows that patients may need to wait up to 6 hours in emergency in Greece.[119] Thereby, the Greek State must adopt a national policy on the management of waiting times and waiting lists, pursuant to which access to medical treatment should primarily be based on transparent criteria, agreed at national level and consider the risk of deterioration in clinical as well as quality of life terms (see Part I, section 4.2.1).[120] Nevertheless, it should be noted that the non-existence of a national policy on the management of waiting lists and waiting times in the ESY makes available information incomplete. But most importantly, such a development

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116 N. Seeman, 'Canada's Missing News—Part II: Lower Infant Mortality Rankings' *Fraser Forum* 2003 (March), pp. 20-21; E. Nolte, A. Brand, I. Koupilová & M. McKee, 'Neonatal and postneonatal mortality in Germany since unification' *Journal of Epidemiology and Community Health* 2000, 54, pp. 84–90.

117 Eurobarometer Qualitative Study, *Patient Involvement*, Brussels: European Commission May 2012, p. 18.

118 Ibid., p. 23.

119 Ibid., p. 22.

120 Ibidem supra note 44, Council of Europe, Recommendation No. R(99) 21, §§ 5,7,12 and 13; See, (Revised) ESC, ECSR, Conclusions XV-2 (2001) - the United Kingdom, volume 2, Council of Europe 2001, p. 601, for an analogous approach.

cannot be considered to meet the requirement of State's responsibility to guarantee the availability and quality of health facilities, goods and services, and as such it creates tension with the right to health framework.

6.4.4 CONCERNS AND STEPS FOR THE FUTURE

The preceding analysis revealed that the Greek health care system and its ensuing policy measures were not designed and developed in light of the right to health framework. Nonetheless, using the international framework of 'AAAQ' under the right to health within the context of health care as an assessment tool we completed an analysis of the performance of the ESY. Accordingly, the inclusion of these key human rights principles, arising from the right to health, in the ESY is minimal. At the same time, like for most European countries, given the increasing health care costs coupled with the implementation of austerity measures generated by the economic crisis from 2010 onwards, it appears particularly important that the Greek State addresses the concerns raised as to the availability, accessibility and quality of health care. Indeed, these principles are under serious threat, in that there is a risk that the Troika's structural adjustment programme will create more problems in access to health care within the ESY in conjunction with the rising health inequalities owed to the worsening socio-economic circumstances (i.e., mainly resulting from the economic crisis and the implementation of the austerity measures), which, in turn, will lead to a (potential) violation of the right to health.[121]

More specifically, the current picture of the ESY appears to be most problematic and raises some issues of great concern with regard to the realization of the 'AAAQ' under the right to health. As already mentioned, primarily due to the State's effort to curtail public health expenditure, the general population, especially vulnerable or marginalized sections of the society, ultimately pays the price by having limited access to health care (emergency care) or losing access to health care, including preventive care (children vaccinations); by facing higher risks of HIV and other communicable diseases; and overall by putting their well-being in danger. When looking at the merging of hospitals and rehabilitation units, combined with the critical understaffing of the health system, it can be discerned that there is great concern in light of the availability and physical accessibility of health care services in Greece. Additionally, the levy of increased user fees and the high prices in medicines makes health care economically inaccessible, especially for the deprived

[121] Such concerns in relation to the severe impact of the financial crisis on the Greek health system have been expressed by the CESCR in its 2015 report to Greece (supra note 57, § 35).

and those most in need for care, such as people with chronic diseases, pregnant women, and children. As such, the increasing payments for health care raise concern in light of the principle of economic accessibility of health care services. Another point of concern is that the policies of 'Troika' put a strong pressure on the scope and quality of basic health care, namely to care which every individual should have access and which is financed by mainly the state budget (tax system) and by social insurance funds. For instance, this becomes obvious by looking at the long waiting times for hospital treatment, which render the performance of ESY poor.

Thus, as analysed in preceding sections, the Greek State takes a number of austerity measures with serious consequences for the realization of the right to health (care). Notably, the implementation of such measures combined with the rising concerns implicates a violation of its right to health obligations, unless the Greek State can justify that every effort has been made to use all available resources for realizing the right to health (care). In other words, a set back in the level of protection of the right to health due to a lack of funds requires a heavy burden of proof on the part of the Greek State (see Part I, sections 3.4 and 4.2.1). Thereto, it must be conceded that the lack of resources cannot be used as an excuse by the Greek State for not securing the core content of the right to health (see Part I, section 3.4), namely the basic health needs of the population, as this should be seen as a (potential) violation of the right to health.

At the same time, beyond revealing the shortcomings of ESY, human rights norms offer guidance on how a health system in general, the ESY in particular, should function in order to meet the right to health standards. As the ESY struggles to meet increasing health care demands with low financial resources, human rights standards offer a consistent basis to guide policy development, health care redesign and resourcing decisions for ESY. Most importantly, key principles under the right to health -the 'AAAQ'- must be embedded explicitly within national law and policy-making for the provision of health care. The practical means by which the Greek State will meet the 'AAAQ' requirements and, ultimately, realize the highest attainable standard of health of the general population within the functioning of the ESY will require not only financial resources, but also a range of resources as well as the means of international co-operation given its poor economic situation (see Part I, sections 4.2 and 4.4). Put simply, beyond financial resources the Greek State must utilize other kinds of resources relevant for the realization of the right to health (care) such as human, organizational, technological resources (see Part I, section 4.2).[122] In addition, another important issue is the appropriate allocation

[122] See, also, UN CRC Committee, Report on the Forty-Sixth Session, UN Doc. CRC/C/46/3,

and prioritization of the existing (even scarce) resources, as an inappropriate and inefficient allocation (i.e. misallocation and/or mismanagement) can serve as an indication that the Greek State does not comply with its right to health duties 'to the maximum extent of its available resources'.[123] Nonetheless, this cannot be done at the expense of other state obligations relating to other core areas, such as education (see Part I, section 4.2.3). The Greek State must implement existing processes and adopt, wherever necessary, new institutional structures (i.e., accountability and monitoring mechanisms) towards the transparent and effective utilization and allocation of the resources at its disposal (see Part I, section 4.2).[124] For instance, the Greek State must take (institutional and administrative) measures to combat the widespread corruption in the public health sector which has, as aforementioned, a negative impact on the level of available resources and on the realization of the right to health (care) (see also section 6.5.2).

Unless the Greek State introduces such measures, resource scarcity (i.e., incapacity) cannot be used as a pretext for not abiding by its right to health obligations. In other words, the Greek State must demonstrate a genuine commitment to secure the right to health (care), namely to increase/allocate the resources required to this end through the adoption of appropriate policies within the context of its fiscal matters and also by means of international co-operation.[125] Additionally, the process of identification, planning and implementation of such policies should be evolving in order to integrate and respond at the general population's health needs, and to ensure that the provision of health care meets the 'AAAQ' requirements under the right to health at all times. All in all, the Greek State must demonstrate willingness to comply with its right to health obligations (Part I, section 4.2).

Last but not least, in July 2013, it appeared that the Greek State sought to meet its obligations under the right to health (care) within the framework of international co-operation with the WHO (see Part I, section 4.4). The Greek State signed an agreement with this international organization for support in the planning of a health care reform for the years 2013-2015, with a view to improving individual

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22 April 2008, Ch VII, § 65 (Day of General Discussion entitled 'Resources for the Rights of the Child- Responsibility of States', 5 October 2007).

123 Article 2 § 1 ICESCR (Annex 2).

124 Ibidem supra note 122, §§ 73-75.

125 See, UN CESCR, General Comment No. 2: *International technical assistance measures (art. 22 of the Covenant)*, 2 February 1990, UN Doc E/1990/23, § 9. The CESCR adopts the term 'adjustment with a human face' to describe the State's efforts to protect ESC rights in terms of its fiscal matters; Ibidem supra note 33, GC No. 3, § 13.

and population-level health outcomes.[126] Particularly, the goal of this agreement, namely ensuring better health outcomes for the population in Greece would be achieved through a comprehensive health-system reform in line with the new European policy for health and well-being, Health 2020. The ultimate aim of the international co-operation is the design of a sustainable and equitable health system, within which access to high-quality care and financial protection can be ensured and with primary health care to be the cornerstone of care and prevention. This health-system reform initiative of the Greek Ministry of Health is also supported by the European Commission Task Force for Greece and the Federal Ministry of Health of Germany. Meanwhile, such a promotion of co-operation may facilitate the development of a comprehensive health infrastructure accompanied with a more efficient use of the existing (scarce) resources, as already mentioned. Note that this state action is in accordance with Article 2 ICESCR which refers to the international co-operation for the realization of the ESC rights at the national level, including the right to health (see Part I, section 4.4). Finally, within the framework of international co-operation the Greek State must insist in its negotiations with the 'Troika' that the terms of its financial assistance are compatible, *inter alia*, with its right to health obligations (i.e., ensure the progressive realization of the right to health) (see Part I, sections 3.4 and 4.4).

6.5. CHALLENGES WITHIN THE HEALTH SYSTEM IN GREECE

It is generally maintained that the landscape of the health system in Greece is characterized primarily by two operational challenges, which are central to its functioning and signal dangers for the realization of the right to health (care), as will be subsequently analyzed (see Part I, section 3.7).[127] Note that the analysis of the two challenges, namely the privatization and the corruption, will be directed solely to one dimension of the right to health, namely the field of health care.

6.5.1. PRIVATIZATION

From a right to health perspective, a critical concern is that the privatization of health care can be detrimental to the equitable availability and accessibility of

[126] WHO Regional Office for Europe, *WHO, Greece sign agreement on support programme for health reform*, WHO/Europe 2013. <http://www.euro.who.int/en/where-we-work/member-states/greece/ sections/news/2013/07/who,-greece-sign-agreement-on-support-programme-for-health-reform> (last accessed April 2, 2014).

[127] See, e.g. with respect to the NHS corruption in Greece, a study of the European Commission (note 12), pp. 54 & 243.

health care, especially for the poor and other vulnerable groups, if poorly conceived and monitored by the State (see Part I, section 3.7.1).[128] Experiences from the past are indicative of the impact that privatization in the provision of health care has on the health of the general population in Greece. More specifically, prior to 1983, health care in Greece was mainly delivered by private actors.[129] Note by way of background that 45 percent of hospital beds were in private clinics, whereas at the same period in France this figure was estimated around 25 percent and in Spain 20 percent. Additionally, the private health sector remained unregulated by the Greek State which was at the expense of the public sector. In fact, the proliferation of the unregulated private health sector led, *inter alia*, to high out-of-pocket payments for health care, which placed excessive financial burdens on the poorest segments of the population, as well as increased disparity in the availability of health care between remote, rural and urban areas in Greece. Health care was commercialized, as access to health care was dependent on the individual's ability to pay. As a consequence, this development affected negatively the general population's health conditions, which was reflected in increasing mortality and morbidity, especially with regard to infant mortality.[130] Apparently, such alarming development was not in conformity with (international and European) human rights law as well as with the Constitution of Greece (sections 3.7.1 and 5.2.1). Meanwhile, it must be conceded that the privatization in the health sector in principle is not in contradiction with the effective enjoyment of the right to health (care) by every individual, as will be subsequently elaborated; the privatization that is not regulated by the State poses a threat to the objectives of the right to health (care) and, finally, to its enjoyment by every individual.

In light of the above disturbing developments, there was a growing demand for a health care reform and, ultimately, this demand led in 1983 to the establishment

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128 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover. UN GA, 67th Sess., Agenda Item 70(b),* UN Doc. A/67/302, 13 August 2012, § 3.

129 S.A. Alexiadou, E.A. Alexiadou & A. Chamalidou, 'The Historical Development of Hospitals in Greece' *Administrative Review* 2005, April-May-June, pp. 23-28.

130 Introductory Report of draft Law on the National Health System addressed to the Hellenic Parliament, pp. 86, 88 & 94; A.D. Alexiadis, *Introduction to Health Law*, Thessaloniki: Dimopoulou Publishing 1999, pp. 75 & seq.; See, also, concerning the issue of commercialization of health care, M. Mackintosh & M. Koivusalo, 'Health Systems and Commercialization: In Search of Good Sense' in: M. Mackintosh & M. Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses,* Hampshire: Palgrave 2005, pp. 3-21.

of a national health system (Law 1397/1983 – founding law of ESY), as elaborately discussed in section 6.2. At the same time, the activities of private health care providers were banned under Article 5 of Law 1397/1983. As a result, during that period efforts were made to either close or absorb the pre-existing private hospitals into the public sector. In 1992 alterations to the system were made as the legislature acknowledged the potential role of private actors in health care. Therefore, Law 2071/1992 under Article 11 § 1 removed the then existing restriction on the establishment of private initiative and allowed the provision of primary, secondary and tertiary health care also by private actors.[131] Even so, there was an ambiguity in Law 2071/1992 as regards to the adoption of monitoring (accountability) mechanisms for regulating the behavior (i.e., position and activities within the system) of private health care providers. In turn, the functional requirements of private actors, namely the operation, staffing and modernization of private clinics, were specified by a number of Presidential Decrees (PD 247/1991, PD 517/1991, PD 235/2000, PD 84/2001 and PD 198/2007).[132] Overall, since the 1990s there has been an increase in the establishment of private diagnostic health centers as well as specialist health care is provided by private actors who are either contracted by social insurance funds or paid directly by patients. Additionally, rehabilitation care and nursing care for elderly and persons with disabilities are mainly provided by private actors.[133] As such, private initiative in health care tends to develop a health sector which has the potential to respond to the health needs of its recipients and to cover existing gaps -deficiencies- within the public health sector in Greece.

Along with the body of legislation, in 2001 a national supervisory body (SEYYP) was created to hold both public and private actors in the health care sector to account in case of failing to realize the right to health (care), as identified in section 6.2.2. As regards to private health care providers, the Body of Inspectors for Health and Welfare Services (SEYYP) primarily aims to monitor the decisions and actions of these providers, namely to look at whether these actors provide care

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131 Ibidem supra note 26, Law 2071/1992.

132 PD 247/1991, *Official Government Gazette* – ΦΕΚ issue Α′ 93/21-06-1991; PD 517/1991, *Official Government Gazette* – ΦΕΚ issue Α′ 202/24-12-1991; PD 235/2000, *Official Government Gazette* – ΦΕΚ issue Α′ 199/14-09-2000; PD 84/2001, *Official Government Gazette* – ΦΕΚ issue Α′ 70/10-04-2001; PD 198/2007, *Official Government Gazette* – ΦΕΚ issue Α′ 225/14-09-2007.

133 See, ESC, ECSR, Conclusions XX-2 (2013) Greece, November 2014, p. 14; 23rd National Report on the Implementation of ESC and 8th National Report, The Government of Greece, pp. 24-25; See, also, European Observatory on Health Systems and Policies, 'Greece - Health System Review', *Health Systems in Transition* 2010, Volume 12, No. 7, pp. 1-180.

that is sufficiently accessible (affordable) and of appropriate quality for its recipients.[134] Thereto, the establishment of this monitoring mechanism reflects the Greek State's intention to acknowledge its responsibility to regulate and supervise the private health sector and to finally meet the state 'obligation to protect', a State's duty stemming from the right to health (Part I, section 3.3).

Since 2010, Greece, after its agreement with the Troika by means of the Memorandum of Understanding (MoU), is undergoing more intensively privatization processes in the context of health care provision. State roles and responsibilities within the context of health care are increasingly transferred to private actors, as the Greek State uses private actors in the delivery of health care.[135] For instance, the Greek State purchases health care, by contracting out health care delivery to private health care providers: medical doctors, diagnostic centers and private hospitals. Meanwhile, Law 3370/2005 under Articles 32, 33 and 34 promotes the co-operation between public hospitals and private law entities, which operate as non-profit making institutions.[136] Accordingly, public hospitals can co-operate with such private institutions as to the treatment of patients in intensive care units of the private institutions. Additionally, doctors can obtain their medical specialization in private institutions after the issuing of a ministerial decision under which the appropriateness of the relevant institution will be judged. Note also that the partnership between public and private health sector introduced by Law 3370/2005 is in line with the (Revised) ESC which provides in Article 11 the co-operation between the State and public or private organizations towards the realization of the right to health.[137] In fact, a ministerial decision, issued in 2011, provides that inpatient care facilities of the public sector, namely ESY hospitals, can be used by private insurance funds.[138] Particularly, a number of hospital beds and other specialist care are disposed by the public health sector to private insurance funds.

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134 Ibidem supra note 18.

135 Articles 17-33 of Law 3918/2011, 'Structural Changes in the Health System and Other Provisions' *Official Government Gazette* – ΦΕΚ issue Α′ 31/02-03-2011, partially amended by Law 4238/2014, Article 8.

136 Law 3370/2005 'Organization and Functioning of Public Health Services and other provisions', *Official Government Gazette* - ΦΕΚ issue Α′ 176/11-07-2005.

137 European Social Charter, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) European Social Charter, 3 May 1996, entered into force 1 July 1999, ETS 163; See Annex 2.

138 Ministerial Decision Υ4a/oik.93320 'Approval of Contracting an Agreement between ESY Hospitals and Private Insurance Companies' *Official Government Gazette* – ΦΕΚ issue Β′ 1842/19-08-2011.

In light of the preceding, it can be observed that under certain circumstances (i.e., primarily under a concrete regulatory framework) privatization is possible to create a window of opportunity for significant positive changes in the provision of health care. In fact, a further argument as to the proliferation of privatization in the provision of health care is that privatization provides an opportunity to cover inefficiencies in public health services and, ultimately, realize national health goals.[139] Indeed, regulated privatization can contribute to the enhancement of health care provision through the application of new health technologies as well as through the creation of competition for more effective, available and higher quality services for all members of the population.[140] As a consequence, the privatization has the potential to enhance timely access to quality services as well as to reduce waiting times for hospital treatment in the NHS (see section 6.4.1).

At the same time, as elaborated in Part I, human rights standards do not regulate whether a State should use a public system, a private system, or a mixture of these two systems (see section 3.7.1).[141] However, each system must abide by the four essential elements of the right to health framework (i.e., the 'AAAQ' requirements) (see section 3.7.1) as well as the Greek State must meet the state 'obligation to protect' (see sections 3.3 and 3.5).[142] This means, as indicated before, that the Greek State has an overall responsibility to oversee the engagement of private actors in the health sector and supervise the health care provision by these actors in the terms of achieving a regulated balance between public and private health sector and guaranteeing a right to health (care) for everyone (see section 5.2.2). This State's responsibility could extend to the imposition of explicit legal obligations on private actors by way of concrete legislative provisions that will ensure a range of safeguards for the effective enjoyment of the right to health (care) by all individuals and especially by marginalised and disadvantaged population groups.[143] All in all, it is important to stress that beyond any correlative responsibility of the private actors in the health sector, the Greek State must not excuse itself from its own primary and overall responsibility for realizing the right to health (care) within its jurisdiction (see section 3.7.1).

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139 E.A. Friedman, 'Building Rights-Based Health Systems: A Focus on the Health Workforce' in: A. Clapham & M. Robinson (eds), *Realizing the Right to Health,* Zurich: Rüffer & Rub 2009, pp. 421-435, p. 428.

140 S. Gruskin & D. Tarantola 'Health and Human Rights' in: S. Gruskin, M.A. Grodin, G.J. Annas & S.P. Marks (ed.), *Perspectives on Health and Human Rights*, New York and London: Routledge 2005, pp. 3-57, pp. 28-29.

141 Ibidem supra note 33, GC No. 3, § 8.

142 Ibidem supra note 5, GC No. 14, § 35.

143 Ibidem supra note 5, GC No. 14, §§ 8, 35, 43(a), 51.

6.5.2. CORRUPTION

Generally, it has been argued that health systems are prone to corruption (see Part I, section 3.7.2).[144] The health system in Greece is characterized by persistent corruption.[145] The level of corruption in the system remains disturbingly high. It is maintained that corruption can be detected at all levels of the ESY, affecting primarily two essential principles, arising from the right to health, namely the accessibility and the quality of health care, as will be subsequently elaborated.[146] An elucidating report on health sector corruption commissioned by the European Commission indicates that corruption within public hospital sector in Greece mainly occurs in health care delivery through informal payments and in procurement processes.[147] This report of the European Commission reveals not only the existence of corruption in the Greek national health system, but also provides a concrete idea about the magnitude of the effect.

Accordingly, a major and visible type of corruption in public hospitals involves informal payments to the members of the medical profession (i.e., state officials), even though they bear a legal/professional duty to make decisions to the best interests of the patients (see also section 6.2.2., *'(v) Members of the Medical Profession'*).[148] More specifically, corruption takes place at the point of health care delivery, where members of the medical profession (mainly surgeons) demand informal payments from their patients. Indeed, the reasons for the patients in engaging in such processes are, *inter alia*, to gain priority in access to health care through bypassing long waiting lists (i.e. reduce time spent on such lists) at overstretched public hospitals (see section 6.4.1), to obtain access to better quality health care and more attention (i.e., preferential treatment) by the medical profession (see section 6.4.3). In fact, since the establishment of the ESY, incidents involving ESY doctors demanding from patients and receiving under-the-table (illegally)

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144 See, e.g., W.D. Savedoff, & K. Hussmann, 'Why are health systems prone to corruption?', in: Transparency International, *Global Corruption Report 2006, Special Focus- Corruption and Health*, London: Pluto Press, pp. 4-13.

145 Ibidem supra note 12, European Commission 2013, pp. 54, 60 and 243.

146 Ibid., p. 29 and 243.

147 Ibid., p. 9.

148 Special Eurobarometer 397, *Corruption Report*, Brussels: European Commission February 2014, pp. 85-95; The Special Eurobarometer 397/ Wave EB79.1 survey on 'Corruption' covers the population of the respective nationalities of the EU Member States, resident in each of the EU Member States. Fieldwork in February-March 2013, published in February 2014; See, also, Law 3418/2005 'Code of Medical Deontology' (note 104); PD 216/2001 'Code of Nursing Deontology' (note 106).

payments have been reported. It is referred to commonly in Greek as *fakelaki* (i.e., small envelope). Indeed, from the side of the members of the medical profession, there is a growing interest in maintaining such unethical transactions-practices (i.e., influence the entry of patients to public hospitals through bypassing waiting lists) in view of demanding from patients additional illicit payments.[149] Nonetheless, this is not to say that all the members of the medical profession are engaged in such illicit and unethical practices.

Beyond the members of the medical profession, another significant sector within the ESY vulnerable to corruption is procurement in health care, where corruption appears to be widespread.[150] In addition, decentralization of procurement processes combined with the lack of strong regulatory mechanisms has increased the risk of corruption within the ESY over the years. Particularly, corruption most frequently occurs in the procurement of medical equipment and of pharmaceuticals. Supply companies exert pressure to public health officials in order to influence regulations and secure favorable public procurement contracts.[151] A 2012 Special Eurobarometer report on corruption revealed that 78 percent of the respondents - the general public- in Greece perceived corruption in the public health sector to be systematic.[152] This survey manifests distrust in the society as a whole with respect to public institutions, including public health care, as a consequence of the several incidents of corruption in Greece.

Meanwhile, such cases of corruption within the Greek national health system implicate violations of the right to health (care) especially with regard to vulnerable groups, as they create barriers for these groups to access health care (see Part I, section 3.7.2). More specifically, poor people, due to their weak economic status (financial capacity), are often denied the care that the State is under the obligation to provide. This means that these people are deprived of using health care and life-saving treatment, as they cannot afford the informal payments (under-the-table

149 Ibid.; Ibidem supra note 12, pp. 60 and 153 (reported incidents of corruption in health care delivery); European Commission, *Annex - Greece to EU Anti-Corruption Report*, COM (2014) 38 final, Brussels: European Commission 2014, p. 12.

150 Ibidem supra note 12, p. 71.

151 Ibid., p. 244.

152 Special Eurobarometer 374, *Corruption Report*, Brussels: European Commission, February 2012, p. 12; The Special Eurobarometer 374/ Wave EB76.1 survey on 'Corruption' covers the population of the respective nationalities of the EU Member States, resident in each of the EU Member States. Fieldwork in September 2011, published in February 2012. Notably, in the 2013 Special Eurobarometer 397 report on corruption (note 148), 99 percent of the respondents in Greece considered corruption to be a widespread national problem.

payments), charged for health care that should be provided free of charge or at lower price. Therefore, corruption constitutes a threat to the affordability of health care within the ESY. In addition, corruption at the level of health care provision may lead to less favorable treatment of patients, who have not engaged in unethical practices (i.e., to respond to under-the-table payment demands), and thus, to the provision of substandard health care on the part of the medical profession. Indeed, it is argued that corruption prevents the enjoyment of the right to health (care) especially with respect to the vulnerable population groups (see Part I, section 3.7.2).[153] At the same time, corruption in procurement processes increases health care costs, while it undermines quality of health care services and goods (e.g. as to the quality of drugs and the medical equipment within the ESY) and ultimately impairs the functioning of the ESY at the expense of the patients.[154] As such, procurement corruption hinders the realization of the right to health (care). The aforementioned issues raise concerns in light of the 'accessibility', 'acceptability' and 'quality' core requirements as set out in the right to health framework (see Part I, section 3.5).

In light of the preceding analysis, tackling corruption constitutes both an enduring concern and a challenging issue in light of the right to health, but with ample opportunities for engagement by the Greek State. Thereby, one significant action is to establish and implement firmly the national and international frameworks against corruption. Greece, already, has anti-corruption laws and policies in place. Most notably, in May 2008 Greece ratified the United Nations Convention against Corruption, which was incorporated into domestic law by Law 3666/2008.[155] However, such initiative of itself is not enough to combat corruption and needs to be embraced fully by the Greek State. Unfortunately, in Greece legislative efforts are often rendered ineffective by uneven or weak enforcement and implementation. The Greek State needs to pay even more attention to law enforcement with the ultimate aim of reducing opportunities for corruption. Indeed,

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153 Ibidem supra note 29, UN Doc. E/CN.4/2003/58, § 98.

154 See, also, W.D. Savedoff & K. Hussmann, 'Why are health systems prone to corruption?', in Transparency International, *Global Corruption Report 2006, Special Focus - Corruption and Health*, London: Pluto Press, pp. 4-13.

155 Law 3666/2008, 'Ratification of the UN Convention against Corruption and replacement of relative provisions of the Criminal Law', *Official Government Gazette* - ΦΕΚ issue Α′ 105/10-6-2008; Of note, Greece has ratified several other conventions on corruption. For instance, in May 2007 the Council of Europe's Criminal Law Convention on Corruption and its additional protocol were ratified with Law 3560/2007, *Official Government Gazette* - ΦΕΚ issue Α′ 103/14-5-2007.

the CRC Committee in its report for Greece expressed its concern about 'the persistence of corruption in public institutions' and called upon Greece 'to increase anti-corruption efforts'.[156]

In order to effectively combat and prevent corruption in the ESY Greece needs to build strong safety nets by putting an explicit emphasis on rigorous supervisory mechanisms (i.e., transparency, monitoring and accountability mechanisms) and by providing legal means of redress accessible to all (see Part I, section 3.7.2).[157] For instance, transparency within the ESY should be promoted and enhanced through publication of waiting lists - waiting times for hospital treatment, so as the management of waiting lists will be based on transparent criteria and not on the individual's ability to pay.[158] The window of opportunity for taking decisive action has rarely been more favorable. Notably, the economic crisis in Greece has offered several opportunities to enhance accountability and transparency within the ESY. In response to a wave of corruption scandals involving ESY sector and pursuant to the economic adjustment programme, the Greek Ministry of Health promoted an enhanced procurement mechanism and the centralization of healthcare procurement. A special Commission, the Procurement Coordination Commission, was established under the auspices of the Greek Ministry of Health, aiming at introducing increased monitoring and transparency in the process of procurement within ESY.[159] Additionally, financial accountability has been imposed through the introduction and implementation of an Electronic Prescription System (e-prescribing) which monitors the prescriptions of drugs and as such results gradually in the reduction of corruption related to pharmaceuticals.[160] It appears that the aforementioned monitoring and accountability mechanisms provide evidence that, to some extent, genuine efforts have been made by the part of the Greek State to set up institutional changes-policies for regulating the behaviour of the State and the non-State actors with the ultimate aim of combating corruption within health care.

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156 Ibidem supra note 30, UN CRC Committee, §§ 17 and 18(f).

157 Ibidem supra note 148, Special Eurobarometer 397, p. 65. Note that 87 percent of the respondents in Greece suggested that high level corruption cases are not sufficiently pursued in Greece.

158 See, for instance, A. First, 'Hospital waiting lists open for scrutiny in Croatia', in: Transparency International, *Global Corruption Report 2006, Special Focus- Corruption and Health*, London: Pluto Press, pp. 55-57.

159 Article 6 of Law 3918/2011, 'Structural Changes in the Health System and Other Provisions', *Official Government Gazette* - ΦΕΚ issue Α′ 31/02-03-2011.

160 Ibidem supra note 12, European Commission, p. 246.

Meanwhile, when it comes to the notion of participation (see Part I, section 3.5) civil society can play a crucial role in fighting and rejecting corruption in the public health sector. Particularly, civil society can help the Greek State to raise awareness about corruption by means of campaigns and strategies.[161] Indeed, a social pressure for continued political commitment against corruption should be strongly maintained. All in all, along with the imposition of monitoring and accountability mechanisms, the possibilities for participation of citizens and enterprises in the formulation of anti-corruption measures should be promoted by the Greek State by way of formal participatory structures accessible to all.

6.6. CONCLUSIONS

Given the rising costs of health care, resource scarcity and increasing health inequalities in Greece, the extent of the Greek State's compliance with its right to health duties must be at all times subject to scrutiny with a view to ensuring the advancement of individual and population health. At the same time it must be, however, conceded that the level of compliance with international health standards is insufficient. There is an apparent contrast between the international standards that Greece has ratified and what is being ultimately implemented by the Greek State within healthcare settings. Indeed, this becomes evident especially if one considers that the national health system in Greece and its ensuing policy measures were not designed in light of the right to health framework (see sections 6.2 and 6.4).

Meanwhile, the most pressing problem and concern as to the realization of the right to health (care) is the implementation of a number of austerity measures in the public health sector. Indeed, when the performance of the national health system was evaluated against the 'AAAQ' requirements, a number of shortcomings in the provision of health care were revealed. It became evident that primarily from 2010 onwards, measures, such as the charge of increased user fees for publicly funded health care and the mergers of healthcare facilities, adopted in the framework of the MoU, have a detrimental impact on the enjoyment of the right to health (care) in Greece. The infant mortality rate as well as health disparities based on low socio-economic status have increased in the country over the course of the last 5 years (i.e. during the economic crisis) and constitute serious points of concern under the 'AAAQ'. Thereto, it must be conceded that such developments clearly

[161] For instance, a civil society reporting website entitled *Edosa fakelaki* (i.e., I gave a small envelope) whereby *fakelaki* refers to a bribe, was created in Greece to raise awareness on the issue of corruption in the public sector, including the health sector - <http://www.edosafakelaki.org>.

reflect the State's failure to comply with its right to health obligations, in that they cause a limitation on the enjoyment of the right to health (care) by individuals, especially by people belonging to vulnerable groups. Unless the Greek State takes (legislative and policy) measures in light of its available (limited) resources to remedy such alarming developments, such as by enacting legislation to prioritize the most urgent health needs of vulnerable groups, this failure will amount to a violation of the right to health (care) of these groups.

Given the economic situation in Greece, the progressive nature of the right to health (care) should not be regarded by the Greek State as a means to excuse its failure to abide by its obligations and based on the assertion of lack of economic growth and of insufficient national resources to adopt retrogressive measures that will undermine the realization of this right, especially concerning vulnerable populations (see Part I, section 4.2.3).[162] Rather, it demands that the Greek State within its (limited) scope of capacity (e.g., by way of optimum prioritization of health in its national budget) to set concrete health priorities (i.e., needs of vulnerable individuals or groups), whilst avoiding misallocation/mismanagement and corruption. As such, in light of the progressive nature of the right to health (care) the Greek State must endeavor to strengthen its health infrastructure by placing emphasis on primary health care, namely the primary step in the health care process and an integral part of the core content of this right (see Part I, section 3.4).

Last but not least, seen privatization and corruption in health care delivery from the perspective of the right to health, the Greek State retains the primary and ultimate responsibility to effectively realize this right. The Greek State is required to pay considerable attention to accountability and monitoring mechanisms for addressing possible failures to realize the right to health (care) of every individual. For that reason the Greek State must ensure in its national law implementation measures (see Part I, section 3.7): (1) the comprehensive regulation and supervision of the behaviour of both public (i.e., ESY) and private health care providers; (2) the review and adjustment of legislation and monitoring mechanisms when they do not achieve the expected results, namely to hold (public/private) health actors to account for possible failures to realize the right to health (care); (3) the establishment of mechanisms for individuals' complaints concerning failure or malpractice by (public/private) actors in the health sector and (4) the promotion of accessible to all participatory mechanisms whose implications so far are not duly considered within the adoption of national law and policies in the area of health, particularly as regards to efforts to combat health sector corruption.

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[162] Ibidem supra note 5, GC No. 14, §§ 31-32.

Looking to the future, the Greek State has to move from adopting a plethora of laws and policies irrespective of the right to health to taking concrete action in actually integrating and implementing right to health standards in the functioning of its national health system. This helps Greece to comply with its right to health obligations and, thereby, to ensure long-term sustainability of a robust public health system grounded on the essential principles of 'AAAQ'.

7 Undocumented Migrants

7.1. INTRODUCTION

Generally, there is growing attention for undocumented migrants within the European Union (EU), who constitute an ever-increasing proportion of the population in Europe[1] and as such their particular position when it comes to the realization of the right to health (care) becomes more visible. Meanwhile, there is serious concern about the impediments migrants in an irregular situation face when accessing health care. In 2011, the European Parliament explicitly recognized that 'in many EU countries equitable access to healthcare is not guaranteed, either in practice or in law, for undocumented migrants.'[2] Likewise, the World Health Organization (WHO) has pointedly noted that national health care policies often discriminate against undocumented migrants by making merely emergency health care available and leading undocumented migrants to limited access to health care and as such, to a delay in receiving medical treatment, until their medical condition reaches an emergency.[3] At the same time it must be conceded that there is no uniform approach of the level of access to health care for undocumented migrants

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1 Frontex-European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union, *Annual Risk Analysis 2014*, Poland: Frontex Risk Analysis Unit May 2014, p.12.; Note that in the second quarter (Q2) of 2015 detections of irregular stay in the EU were almost 40% higher compared to the same quarter of 2014. (Frontex-European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union, *FRAN Quarterly- Quarter 2 (April-June 2015)*, Warsaw: Frontex Risk Analysis Unit September 2015, p. 14)

2 European Parliament resolution of 8 March 2011 on Reducing Health Inequalities in the EU, (2010/2089 (INI)) § AD, <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NON SGML+TA+P7-TA-2011-0081+0+DOC+PDF+V0//EN> [last accessed 20 December 2013].

3 WHO, *International Migration, Health & Human Rights*, Health & Human Rights Publication Series No. 4., Geneva: World Health Organization 2003, p. 23.

between the Member States of the EU and there are differences in the way access to health care for undocumented migrants is guaranteed and regulated within their jurisdiction by their respective national legislature.[4] Thereto, Members States of the EU, like Greece, have adopted their own national definition on the issue of what level of health care should be available to undocumented migrants by reflecting their particular circumstances and starting points.[5] Interestingly, it is notable that due to the scarcity of available resources within a State's jurisdiction, the focus of a State's attention could shift from the realization of the general right to health obligations to the realization of core obligations, despite the controversy surrounding their acceptance and definition (see Part I, section 3.4). These core obligations aimed at the realization of the right to health (i.e. its minimum requirements) if acknowledged by States can be a practical tool (albeit used with due caution) for low-income States, like Greece, to discern certain health services that should be available to marginalized population groups without financial means, such as undocumented migrants.[6] Meanwhile, it is essential to note that this does not imply that Greece will deny the remainder of the right to health (i.e., abdicate its ensuing duties and stop taking steps) and once it has realized the core (see Part I, section 3.4).

In light of the analysis in Part I and the above concerns, this chapter seeks to investigate Greece in relation to its compliance with its binding right to health obligations towards undocumented migrants within the context of health care. The underlying preconditions for health will be addressed where relevant. Notably, in terms of this objective, in section 7.3 it is useful to briefly set out the constitutional parameters that conceptualize the State obligations concerning the right to health (care) for undocumented migrants. Subsequently, we will draw attention to the way such obligations are operationalised within national law and policy context

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4 See, e.g., D. Biswas, B. Toebes, A. Hjern, H. Ascher & M. Norredam, 'Access to Health Care for Undocumented Migrants from a Human Rights Perspective: A Comparative Study of Denmark, Sweden, And the Netherlands', *Health and Human Rights* 2012, Volume 14, No. 2, pp. 49-60.

5 European Union Agency for Fundamental Rights, '*Migrants in an irregular situation: access to healthcare in 10 European Union Member States',* Luxembourg: Publications Office of the European Union 2011; International Organization for Migration, *European Research on Migration and Health*, Geneva: IOM 2009.

6 K.G. Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' *The Yale Journal of International Law* 2008, Volume 33, pp. 113-175, p. 173. Note that the definition of minimum entitlements (i.e. core obligations) can be a useful tool that can be utilized by marginalized and vulnerable groups to lodge claims for the realization of their rights, including the right to health.

with special focus on the State approach for undocumented migrant children and on the role of NGOs. Finally, specific health-related challenges that impede and threaten the effective enjoyment of the right to health (care) by undocumented migrants coupled with steps forward will be addressed in section 7.4. But firstly, section 7.2 elucidates the term 'undocumented migrants' and their health status.

7.2. UNDOCUMENTED MIGRANTS AND THEIR HEALTH STATUS

Undocumented migrants represent a heterogeneous group, which generally involves individuals who enter or stay in a country without the appropriate documentation and, thereby, lack legal status in the host country.[7] More specifically, this group includes people who have (a) no legal documentation to enter a country but entered clandestinely, (b) been rejected for asylum, (c) stayed beyond the time authorized (i.e., visa/ residence or work permit expiration) or otherwise violated the terms of entry and remained without authorization (i.e., revoked visa/ residence or work permit). [8] In light of the above, we will use the term undocumented instead of 'illegal' migrant. The latter is not a preferable term, as it has a negative connotation by equating all undocumented migrants to criminals.[9]

In general, within the EU, the number of undocumented migrants was estimated to be between 3 and 6 million in 2014.[10] Over the years, Greece, in virtue of being one of the frontier States of the EU, has become one of the main entry points to the EU for individuals coming from outside of the EU, and not having the status of EU citizen.[11] Thousands of migrants, coming primarily from developing countries, enter Greece in an irregular status. Note that in Greece during the second quarter (Q2) of 2015 a 690% increase in irregular border-crossings was reported in relation to the Q2 of 2014, which indicates that the pressure of irregular

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7 See, Article 5 MWC; International Migration Law No. 25, *Glossary on Migration,* (2nd ed.) Geneva: International Organization for Migration 2011; European Observatory on Health Systems and Policies Series, *Migration and Health in the European Union*, England: Open University Press 2011, pp. 149 and 191.

8 Ibid.

9 UN CMW, *General Comment No. 2 on the rights of migrant workers in an irregular situation and members of their families*, UN Doc CMW/C/GC/2, 28 August 2013, § 4.

10 Ibidem supra note 1, Frontex 2014. In 2013, 344,888 detections of illegal stay within the EU were reported (p. 52). However, there are no official estimates of the annual flow of all people entering and staying illegally in the EU.

11 Infra note 105, UN Special Rapporteur; See, European Centre for Disease and Control, *Joint technical mission: HIV in Greece 28-29 May 2012*, Stockholm: ECDC 2013, p. 14. Since 2010, Greek borders have accounted for 90% of all detections of unlawful border crossing into the EU.

migration remains high.[12] The number of undocumented migrants in Greece is estimated around 470,000, constituting almost 5% of the total population in Greece.[13] Nonetheless, it should be emphasized that there is a lack of proper data to describe the issue concerning undocumented migrants and to precisely determine the population size due to the clandestine nature of their entrance and residence in Greece. Even so, from the above figures it is evident that irregular migration represents an increasing proportion of the population in Greece.

Meanwhile, migration could be regarded as a social determinant of health in that the health status of migrants at a large part is related to and influenced by migration conditions, such as the travel conditions (mode and length of travel), living conditions, and their legal and socioeconomic status in the origin and destination country.[14] In May 2008, at its 61st meeting, the World Health Assembly (WHA) in its 61.17 resolution (adopted as a way of guiding future national policies) recognized that 'health outcomes can be influenced by the multiple dimensions of migration', namely can be dependent on the category of the migrant (i.e., regular or irregular).[15] As such, migrants in an irregular situation due to their weak legal and socioeconomic status, can be more (i.e. double) vulnerable to contracting and suffering from severe chronic diseases, thereby putting their physical and mental health at risk, compared to any other population group – the 'average person' among Greece's population.[16] A recent study carried out by Médecins du Monde indicated that 50.8% of undocumented migrants in Greece reported to have poor mental health in 2012 compared to a 9.3% of the general population in Greece.[17] It is indicative that Post-Traumatic Stress Disorder (PTSD) is a significant cause

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12 Ibidem supra note 1, Frontex 2015, p. 16.

13 Ibidem infra note 105, UN Special Rapporteur, § 9.

14 CSDH, *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on the Social Determinants of Health*, Geneva: World Health Organization, 2008. Accordingly, the way, in which people are raised, live and work, determines their state of health (p. 42); Ibidem supra note 7, European Observatory on Health Systems and Policies Series 2011.

15 World Health Organization, *Sixty-First World Health Assembly, Resolutions and Decisions Annexes*, WHA 61/2008/REC/1, 19-24 May 2008.

16 Platform for International Cooperation on Undocumented Migrants, *Access to Health Care for Undocumented Migrants in Europe*, Brussels: PICUM 2007; H. Castañeda, 'Illegality as risk factor: A survey of unauthorized migrant patients in a Berlin clinic', *Social Science and Medicine* 2009, 28 (8), pp. 1552-1560.

17 Médecins du Monde, *Access to Healthcare in Europe in Times of Crisis and Rising Xenophobia*, France: Médecins du Monde 2013, p. 7; OECD, *Health Data on perceived health status 2000-2013*, <www.oecd.org>

for concern for this population group, being exacerbated by the constant fear of detention and deportation, and requiring follow-up care, as a result.[18]

Arguably, this matter raises serious questions, *inter alia*, about the extent of access to health care for undocumented migrants due to their weak status within society. In recognition of this issue, on 8 March 2011, the European Parliament adopted a resolution, namely 'Reducing health inequalities in the EU', to urge and assist Member States in developing appropriate policies that will 'ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare; … assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation'.[19] As such, the Greek State, by adopting the general population's health as a goal, can design and develop targeted health interventions that effectively meet the needs of all segments of the population, including the most vulnerable population groups, like undocumented migrants.[20] This implies that the living reality of undocumented migrants, namely the particular circumstances under which these people live by virtue of the lack of legality of their status, should influence the process of identification and development of comprehensive context-sensitive national health policies (see Part I, section 4.2). In fact, the increased level of vulnerability (i.e., double vulnerability: as migrants and as undocumented) with regard to their prospects for effective enjoyment of their right to health (care) entails that the special health needs of this population group must be addressed in the design and implementation of State measures relating to such needs (i.e., migrant-sensitive health measures).[21] At the same time, this vulnerability implies that the impact of

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[18] See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 4th Sess., Agenda Item 2*, UN Doc A/HRC/4/28/Add.2, 28 February 2007, § 44.

[19] Ibidem supra note 2, European Parliament, § 5.

[20] The first Special Rapporteur on the Right to Health (Paul Hunt) stressed that asylum-seekers and undocumented migrants 'are precisely to the sort of disadvantaged group that international human rights law is designed to protect' (supra note 18: § 73). It should be, though, emphasized that failed asylum seekers constitute a considerable part of the undocumented population residing in Greece.

[21] See, e.g., UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000, §§ 21-22 read in conjunction with UN CESCR, General Comment No. 20: *Non-Discrimination in Economic, Social and Cultural Rights*, UN Doc. E/C.12/GC/20, 2 July 2009, § 30. Note that the CESCR identifies a number of vulnerable groups, among which non-nationals without a legal status, to which

such health-related measures on undocumented migrants is likely to be more profound than in regard of someone who does not have special health needs. The point to stress therefore is that given undocumented migrants' lower health status compared to nationals, State's attention to access to health care and to areas such as immunization, prevention of transmission and appropriate treatment of chronic and infectious diseases and of mental health conditions through provision of psychological support, can be a significant first step towards ensuring effective protection and improvement of their health condition.[22] As a consequence, both individual and population health may benefit in the long-term.

7.3. HEALTH-RELATED LAW AND POLICY

7.3.1. SETTING THE SCENE

As mentioned in Chapter 6, in broad terms, the Greek National Health System (in Greek: Ethniko Systima Ygeias, ESY) is mainly based on two financing methods, namely on state budget (i.e. from taxation) and on a social insurance system.[23] In essence, this covers all Greek citizens and authorized residents who work or receive unemployment benefits. Thereby, access to public health care in Greece is cost-free for those having insurance, nationals and authorized residents. Additionally, Greek nationals and authorized residents with low or no income and without an insurance coverage can obtain a welfare card in order to receive cost-free public health care.[24] At this point, it is, though, essential to mention that during the 2010-2015 years when Greece was hit by the economic crisis, the Greek State generated a number of austerity measures, including the increase of user fees for publicly funded health care. Such an increase, nevertheless, placed an excessive financial burden especially on the poorer segments of the society (see section 6.4.2.3).[25] Consequently, these

States are required under the right to health to give special attention through developing targeted health policies (see Part I, section 4.2.1).

22 Ibidem supra notes 3 and 17.

23 L. Liaropoulos & E. Tragakes, 'Public/private financing in Greek health care system: Implications for equity' *Health Policy* 1998, 43, pp. 153-169, p. 153; See, for an elaborate assessment of the Greek National Health System Chapter 6 of the present study.

24 Article 44, Law 2082/1992, *Official Government Gazette* -ΦΕΚ issue Α′ 158/21-09-1992; See also, Joint Ministerial Decision, 139491/16-11-2006, *Official Government Gazette*-ΦΕΚ issue Β′ 1747/30-11-2006.

25 For instance, as from 1 January 2014, a €25 entrance fee for public hospitals and healthcare centers was established (Article 1(IB.2) (12), Law 4093/2012, *Official Government Gazette*-ΦΕΚ issue Α′ 222/12-11-2012). Note that this measure was never implemented due to pressure exerted from the Greek society. See, also, Government of Greece, Letter of Intent,

cost-benefit measures (co- payments) exclude a considerable number of people, especially those belonging to vulnerable groups of society, from having access to health care and may have a negative effect on health outcomes in the long-term.[26]

With regard to migrants, access to health care is dependent on registered employment and legal status. In particular, practices in access to health care for undocumented migrants in Greece are related to the context of the existing national legislation. Notably, increased migration coupled with the rising costs of the national health system (ESY), have led Greece to explicitly limit access to health care for undocumented migrants in its legislation in an effort to reduce its health care expenses. By looking at this legislation, it is apparent that the respective law provisions allow some differentiation in the provision of health care between Greek nationals and undocumented migrants. For that reason, it is essential first to examine the key existing legislation, which imposes specific health-related obligations upon the Greek State with respect to access to health care for undocumented migrants. Then, we will identify whether the respective law provisions and applied practices are in conformity with human rights standards that are binding for Greece. But for the purposes of the present chapter, it is advisable to briefly define the constitutional parameters conceptualizing State obligations under the right to health by paying particular attention to the dimension of 'access to health care' for undocumented migrants, before embarking on our analysis of health care provisions for undocumented migrants.

7.3.2 CONSTITUTIONAL ENTRENCHMENT

Generally speaking, the extent of health care coverage for undocumented migrants is closely intertwined with the State obligations arising from the right to health within the context of determining health policies and defining a level of entitlement to health care applicable to every individual, including undocumented migrants. In literature it is maintained that States are responsible for creating the legal conditions for the fulfillment of their right to health obligations, targeted to the health needs of undocumented migrants.[27] Hence, at the constitutional level, there

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Memorandum of Economic and Financial Policies and Technical Memorandum of Understanding 2012.

[26] M. Mackintosh & M. Koivusalo, 'Health Systems and Commercialization: In Search of Good Sense' in: M. Mackintosh and M. Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses,* Hampshire: Palgrave 2005, pp. 3-21, p. 8; See, also, Section 6.4.2.3 on the issue of economic affordability within the ESY.

[27] R. Romero-Ortuño, 'Access to health care for illegal immigrants in the EU: should we be concerned?' *European Journal of Health Law* 2004, Volume 11, pp. 245-272, p. 266.

are several provisions of importance and relevance that entrench an entitlement to health (care) for undocumented migrants in Greece. The Constitution of Greece (henceforth: the Constitution) recognises such an entitlement for undocumented migrants as well as entails respective general state obligations under two ways.[28] More specifically, undocumented migrants are entitled to health (care) pursuant to specific constitutional provisions on the right to health as well as pursuant to general health-related constitutional provisions (i.e., provisions on protection of life and of human dignity coupled with the general guiding principles of non-discrimination and equality).[29]

Notably, Article 5 § 5 of the Constitution constitutes a key provision for such an entitlement for undocumented migrants. This provision makes an explicit reference to the right to the protection of everyone's health living within the Greek territory. Particularly, this provision establishes a right to health, being applicable to every individual, *inter alia,* to undocumented migrants (see section 5.2.1). In addition, as elaborately analysed in section 5.2.1, the Constitution under Article 21 § 3 formulates a general positive obligation on the part of the Greek State for the health of all *citizens* in Greece. Meanwhile, the general wording of this provision allows for a distinction between *citizens* and *non-citizens*. Nevertheless, given that the Constitution provides no conceptual clarity on the content of the term *citizens*, it can be argued that Article 21 § 3 applies, *inter alia*, only to migrants who meet certain legal conditions, such as lawful residence or regular work in Greece. As such, legal migrants are considered to be active members of the Greek society and are entitled to similar access to health care as Greek citizens. On the other hand, access to health care for undocumented migrants should be regulated depending on their migration status, as they are not considered to be members of the Greek society due to the legality status of their presence. As such, this group (i.e., undocumented migrants) can be implicitly denied protection under this provision. Nevertheless, the ambiguity of the content of the term *citizens* gives discretionary power to the Greek authorities with regard to the interpretation of this constitutional provision.[30]

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[28] The *Constitution of Greece (1975-1986-2001-2008*), as revised by the parliamentary resolution of 27 May 2008 of the VIII[th] Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue A′ 120/27-06-2008. The texts of the Constitution of Greece are the Official translation of the Hellenic Parliament available at <www.hellenicparliament.gr>; As regards to the supremacy of the Constitution of Greece within national legal order, see section 5.2.

[29] For an overview of health-related rights, namely rights connected to the protection of health, see, also Chapter 2, Section 5.3 and Annex 1 of the present study.

[30] K. Chrisogonos, *Individual and Social Rights,* Athens: Nomiki Bibliothiki 2006, p. 51.

In the meantime, we will look at the notion of the entitlement to health (care) for undocumented migrants also from the perspective of rights that are potentially relevant and can reinforce such entitlement for this population group (i.e., from the right to life and human dignity to the principles of non-discrimination and equality). Moreover, the general legal principles, enshrined in the Constitution, which are compatible with a human rights approach to health (care), could serve as a tool for the interpretation of specific legal provisions within health care settings and for guiding health policies and programmes addressed to every individual, including undocumented migrants.

Of particular interest is the broadly formulated Article 5 § 2 of the Constitution, which may extend its protection against discrimination, based on *nationality* within health-care domain for undocumented migrants (see section 5.3). In this regard, undocumented migrants are constitutionally protected in such a way that their access to health care is implicitly guaranteed through the protection of their life and human dignity, albeit reflecting a minimum level of protection, minimum care treatment. Note that the European Committee of Social Rights (ECSR) maintained such position in the case of *FIDH v. France,* which provides an interpretation of the (revised) ESC concerning undocumented migrants' access to health care, albeit not strictly legally binding for the respective States (see Part I, section 4.3).[31]

Similarly, a minimum entitlement to health (care) for undocumented migrants can also be implicitly guaranteed under Articles 2 § 1 and 7 § 2 of the Constitution, which address human dignity and freedom from inhuman and degrading treatment, respectively (see section 5.3). Under the preceding constitutional provisions, such an entitlement is intertwined with the protection of human value and dignity in such way to consider the denial of access to health care on the basis of the legality of a person's presence being non-justified.[32]

Last but not least, the above general health-related constitutional provisions should be read in conjunction with Article 25 § 1 of the Constitution which establishes the principle of welfare State (see section 5.3). Particularly, the general wording of this provision implies that every individual is entitled to the enjoyment of his or her rights and that the Greek State is under the obligation to secure this enjoyment through the adoption of measures. As such, an expansive protection is granted under this substantive provision that may extend to an entitlement to health (care) for undocumented migrants.

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[31] *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 14/2003, 3 November 2004, §§ 31-34.

[32] Ibidem supra note 30, pp. 553-554.

All in all, the constitutional entrenchment of the legal entitlement to health (care) for undocumented migrants is a step for the Greek State towards complying with its binding treaty obligations for this vulnerable group. Thereby, the Constitution, in principle, establishes both an entitlement for undocumented migrants and a general state obligation not to deny such an entitlement on the basis of an individual's legal status. Nevertheless, this constitutional entrenchment does not allow for exhaustive conclusions about its actual scope within the national law and policy context. The existing constitutional framework provides for the Greek State flexibility in terms of defining this scope through the creation of the conditions for the fulfillment of its duty. In practical terms, this means that this scope will be clarified through the elaboration of relevant national legislation and policy documents. For this reason, subsequent attention will be drawn to the examination of the respective law provisions, applied policies and practices with the aim of identifying the actual level of enjoyment of such an entitlement by undocumented migrants, followed by areas of concern and steps forward in light of the international guaranteed right to health.

7.3.3. UNDOCUMENTED MIGRANTS AND ACCESS TO HEALTH CARE

Greece has introduced explicit legal provisions governing the access to health care for undocumented migrants in the Greek territory under Immigration Law 3386/2005 (Article 84 § 1), which was later amended by Article 26 § 1 under Code for Migration, Law 4251/2014.[33] More specifically, both aforementioned provisions provide expressly that no public authority is allowed, under the threat of sanctions, to provide its services to third countries' nationals, who do not have a passport or any other legal document (identification documents) required by the current international agreements, European law; or an entry visa; or a residence permit; and generally who cannot prove that they have entered and reside legally in Greece.[34] Here, both

[33] Law 3386/2005 on 'Entry, Residence and Social Integration of Third-Country Nationals in the Greek Territory', *Official Government Gazette*- ΦΕΚ issue Α′ 212/ 23-08-2005; Law 4251/2014 'Code for Migration and Social Inclusion and other Provisions', *Official Government Gazette*- ΦΕΚ issue Α′ 80/01-04-2014. Note that under Article 1 § 1 Law 4251/2014, a migrant is defined as a citizen of a third country, person who does not have the Greek citizenship neither the citizenship of any other Member State of the European Union. This definition was first introduced by Law 3386/2005.

[34] In case public servants (doctors, nurses etc.) violate the provisions of article 84 of Law 3386/2005, they will be disciplinary and criminally liable for having infringed their duties according to Article 84 § 4 of Law 3386/2005. In fact, the Greek Ministry of Health issued an urgent Circular that reiterates the above provision and strongly highlights the obligations

provisions clearly address the ('illegal'/ irregular) status of undocumented migrants. In particular, it becomes apparent from the wording of the aforementioned law provision that the ability of the migrants to prove their legal residence status in Greece is an essential element in order to access (primary and secondary) healthcare. However, the respective Law provisions explicitly recognize an exception for their access to hospitals and clinics in case of an emergency as well as in case of childbirth, which was added, belatedly perhaps, in Article 26 § 2(a) of Law 4251/2014.

In light of the above, undocumented migrants are granted limited access to health care due to their status, which also involves payment of specific components, such as laboratory tests and medicines.[35] However, since 2005, the respective law provisions do not define what constitutes emergency medical care (see Part I, section 4.3). The decision whether a situation should be regarded as an emergency or not is left to the discretion of the members of the medical profession, providing treatment.[36] In some cases, however, such difficulty can be particularly detrimental to undocumented migrants with chronic diseases, such as HIV/AIDS. A critical concern is the HIV/AIDS prevalence in Greece, since an increasing number of people died of HIV/AIDS from 2007-2009 combined with a 57% rise in 2011 in the number of reported HIV/AIDS infections as compared to 2010.[37] Although there is no evidence that undocumented migrants are mostly affected by HIV, it is noteworthy that even though access to HIV testing is free in public hospitals and screening centers and the need for antiretroviral drugs is considered a life-threatening emergency, in practice undocumented migrants' continuous access to antiretroviral therapy depends on the decision of the health professional.[38]

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and liability of public servants (Circular Y4a/oik.45610/02-05-2012). Further, the punishment of public servants is also provided under Article 26 § 4 of Law 4251/2014.

35 ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, January 2014, p. 36.

36 For a definition of the term 'emergency' within Greek case law, see, *inter alia*: Council of State Decisions 632/1999, 866/1997, 5421/1995 and Administrative Court of Athens Decision 4494/2002. Pursuant to the aforementioned court decisions, 'emergency' is defined as a life threatening situation.

37 UN CEDAW Committee, CO: Greece, UN Doc. CEDAW/C/GRC/CO/7, 1 March 2013, § 30; Greek Ministry of Health and KEELPNO*, HIV/AIDS Surveillance in Greece- Annual Report of the HCDCP*, No. 26, December 2011, p. 13; For HIV/AIDS prevalence in relation to migration, see European Centre for Disease Prevention and Control/WHO Regional Office for Europe, *HIV/AIDS Surveillance in Europe 2012,* Stockholm: European Centre for Disease Prevention and Control, 2013, pp. 6 and 18. Note that more than one third of the heterosexually acquired HIV cases were reported in migrant population coming from highly endemic countries, mainly sub-Saharan Africa.

38 European Centre for Disease and Control, *Joint technical mission: HIV in Greece 28-29*

Meanwhile, in an effort to provide further clarification about the normative content of emergency medical care for undocumented migrants, the Greek Ministry of Health has issued two important Circulars in 2005 and in 2012 respectively, aiming at conceptualizing the respective law provisions within the health care policy context. Specifically, the 2005 Circular of the Greek Ministry of Health provides that undocumented migrants will receive necessary health care only in cases of an emergency and until their health has been 'stabilized'.[39] Here, the strict notion of emergency medical care is supplemented by two more flexible notions of necessary health care and 'stabilization', which would enable treatment, such as regular follow-ups with the doctor, to be considered as part of the concept of emergency medical care. However, no legislative provision gives clarity with regard to the vague concept of the term 'stabilization' and, thereby, once again members of the medical profession are left to decide on this issue, namely on a case-by-case basis.

In 2012, due to high irregular migration flows combined with the rising costs of health care, the Greek Ministry of Health issued an urgent Circular (henceforth: 2012 Circular) with the aim of giving further explanations about access to the hospital, medical and pharmaceutical care system of the country by uninsured aliens, including undocumented migrants.[40] Particularly, the 2012 Circular stresses that recognized refugees, asylum seekers, beneficiaries of supplementary protection and those subject to the protection regime for humanitarian reasons may be subject to the system of free medical, pharmaceutical and hospital care of the country under certain conditions. Moreover, the same Circular provides for the inclusion in the system of free medical, pharmaceutical and hospital care of the legally residing third-country nationals.[41] With respect to undocumented

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May 2012, Stockholm: ECDC 2013, pp. 6 and 14; Médecins du Monde, *European Survey on Undocumented Migrants Access to Health Care*, European Observatory: Médecins du Monde 2007. <http://www.mdm-international.org/IMG/pdf/rapportobservatoireenglish-2.pdf>; Note that under a ministerial circular (Greek Ministry of Health), namely Y4a/oik 89-29/12/2005, undocumented migrants can receive antiretroviral therapy on condition that his/her physician can certify that such treatment is not available in the country of his/her origin.

39 § 5, Circular OIK/EMP518/ 21-02-2005 on 'Healthcare for Migrants'.

40 Greek Ministry of Health, Circular Y4a/oik.45610/02-05-2012, 'Clarifications with respect to the access of the uninsured and aliens to the system of medical, pharmaceutical and hospital treatment of the country'.

41 Ibid.; Note also that in 2006 the Greek Ministry of Health in line with the PD 266/1999 (Articles 15-17) issued a Ministerial Decision under the number 139491/16-11-2006 (*Official Government Gazette*- ΦΕΚ issue Β΄ 1747/30-11-2006). More specifically, it provides the 'requirements, definition, criteria and procedures for access to the system of nursing and health care uninsured and financially weak people'. Accordingly, only migrants who reside

migrants, it is noted that this population group is covered only in cases of an emergency (i.e., concerning a life threatening situation) and, particularly, when they are admitted through an emergency department of a hospital. The 2012 Circular, also, adds that access to health care for undocumented migrants is provided in critical cases of treatment of certain communicable diseases, including treatment for HIV/AIDS. In addition, it notes that such cases shall be covered until the 'stabilization' of the health of undocumented migrant patients, without though once again elaborately defining the content of this term. Nevertheless, this implies that undocumented migrants with HIV/AIDS or other communicable disease should be admitted if they are seriously ill and in immediate danger, but they will not be eligible for further care after their discharge from hospital. Thereby, the 2012 Circular explicitly asserts that undocumented migrants are not entitled to access health care beyond emergency situations, including treatment for certain communicable diseases that constitute a public health hazard.[42]

Last but not least, as regards undocumented migrant women, beyond obtaining emergency care treatment and care during childbirth, there is no concrete legal obligation to ensure the provision of appropriate pre- and post-natal care. This means that under Article 26 § 2(a) of Law 4251/2014 these women are entitled to receive medical care solely linked to obstetric complications related to pregnancy, a condition that constitutes an emergency, and to childbirth, without having access to other forms of care, including pre-natal or post-natal care.

7.3.4. UNDOCUMENTED MIGRANT CHILDREN AND ACCESS TO HEALTH CARE

For undocumented migrant children, present within the Greek territory, the Greek State applies a different standard in comparison to undocumented migrant adults.[43] More specifically, Law 4251/2014 in Article 26 § 2 combined with the 2012 Circular makes a specific distinction regarding children unlawfully residing in Greece.[44] Accordingly, it is explicitly provided that children, whether accompanied

legally in Greece with a residence permit on humanitarian grounds are entitled to free medical care.

42 Ibidem supra note 40.

43 Note that Greece defines children as all human beings below the age of 18, which is also in line with the CRC definition (see Article 121(1) of the Greek Penal Code in conjunction with Article 127 of the Greek Civil Code, where there is an implicit definition of children, and Article 1 CRC).

44 Ibidem supra notes 33 and 40.

or not and regardless of their legal status or that of their parents, are entitled to receive the same health care under the same conditions as legal migrants and Greek nationals.[45]

The introduction of this exception in line with the CRC which constitutes supreme national law, reflects that the legislature in Greece seems to acknowledge that children, by reason of their physical and mental immaturities, need special safeguards and care, including legal protection, and should not be discriminated on the basis of their dependency upon the status, activities of other people, such as their parents, legal guardians or family members.[46] The respective law provisions in principle recognize that children must be medically treated irrespective of their legal status and unimpeded access to health care must be ensured for this vulnerable population group.

In practice, however, the Committee on the Rights of the Child (CRC Committee) in its 2012 CO on Greece expressed its concern with regard to the limited level of access to health care for undocumented migrant children, primarily in light of the principle of 'economic accessibility' (see Part I, section 3.5).[47] Notably, in 2012 the CRC Committee reiterated its concern about the poor access to health care for undocumented migrant children, expressed in previous observations for Greece in 2002.[48] The Committee, then, had, also, suggested that undocumented migrant children should have sufficient access to health care, including psychological care.[49] In this respect, the Committee, having acknowledged that its recommendations have been insufficiently or partly addressed, urged once again Greece to ensure that undocumented migrant children have equal access to health without discrimination on any ground.[50] Nonetheless, it must be conceded

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45 Ibid.

46 See, preamble and Article 2(2) CRC (20 November 1989, entered into force 2 September 1990 1577 UNTS 3); With respect to the notion of family, the jurisprudence of the ECtHR has recognised as family members non-married partners, children born out of wedlock, dependent adult children. The ECtHR in its case law affirms the existence of family ties regardless of the marital status, the gender identity or sexual orientation. For instance, see, *Onur v. the United Kingdom* (Application no. 27319/07) ECtHR 17 February 2009, § 43-44; *Ciliz v. the Netherlands* (Application no. 29192/95) ECtHR 11 July 2000, § 59; *Schalk and Kopf v. Austria*, (Application no. 30141/04) ECtHR 24 June 2010, § 91 and 94; Greece has ratified the CRC and incorporated it by Law 2101/1992, *Official Government Gazette*-ΦΕΚ issue Α΄ 192/02-12-1992.

47 UN CRC Committee, CO: Greece, UN Doc. CRC/C/GRC/CO/2-3, 13 August 2012, § 52.

48 UN CRC Committee, CO: Greece, UN Doc. CRC/C/15/Add.170, 2 April 2002, § 56(e).

49 Ibid., § 69(f).

50 Ibidem supra note 47, UN CRC Committee 2012, §§ 7, 26, 27(b) and 53.

that the CRC Committee beyond general exhortations and recommendations has not addressed in detail the position of undocumented children in Greece (see also Part I, section 4.2.2). Perhaps, the Committee has tended to avoid this discussion and to be confined to reiteration of concerns rather than provide any real insight into the measures required by the Greek State in this respect.

7.3.5. THE CRITICAL ROLE OF NGOS

Increased irregular migration combined with limited access to health care for undocumented migrants have led to the proliferation of the number of Non Governmental Organizations (NGOs) working in the field of assistance and promotion of rights parallel to the Greek State.[51] In Greece, NGOs, such as Médecins du Monde-Greece and Médecins Sans Frontières-Greece, have undertaken several activities-programmes dedicated to the promotion and protection of undocumented migrants' health in response to the limited access to health care provided by the Greek State. Thereby, NGOs have assumed an increasingly important role in granting undocumented migrants the needed health care, involving primary health care, preventive care, vaccinations, early diagnosis and medical follow up, maternal and reproductive care and psychological support (see also section 7.2).

Note by way of background that Médecins du Monde Greece (MdM-Doctors of the World), the Greek branch of MdM, has opened five polyclinics where volunteer health and social professionals treat undocumented migrant patients. The first of these clinics began its operation in Athens in 1997, while they are now available in Greece's five largest cities, namely in Athens, Chania (Crete-2007), Perama (next to Pireus-2010), Patras (2012) and Thessaloniki (2001).[52] The working hours of the polyclinics are adapted to the health needs of the individuals and are open on a regular basis per week. Moreover, in December 2010, Médecins du Monde Greece responded to the increased irregular migration influxes and operated two mobile units to assist access to health care in Patras and Igoumenitsa, harbor towns located on the western coast of Greece.[53] Meanwhile, Médecins Sans Frontières (MSF) has been providing medical assistance to undocumented migrants in Greece from 1996 until 2004 and from 2008 until today. Mainly since 2008,

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[51] See, e.g., Médecins du Monde, *Access to Healthcare in Europe in Times of Crisis and Rising Xenophobia*, France: Médecins du Monde 2013, p. 4.

[52] Ibid., p. 30; See also, Médecins du Monde-Greece, *Programmes of Medical and Psychological Support,* Greece: MdM <http://www.mdmgreece.gr>.

[53] Médecins du Monde, *Access to Health Care for Vulnerable Groups in the European Union in 2012*, France: Médecins du Monde 2012, p. 17.

Médecins Sans Frontières Greece responded to the lack of health care at the detention centers in regions of Evros (i.e., Filakio, Soufli, Tichero and Feres) and volunteered to treat detained undocumented migrants in serious need for health care and psychological support, principally related to the poor detention conditions and to the lack of access to regular medical care.[54]

In light of the above, it appears that the initiatives undertaken by NGOs, such as the MdM-Greece and MSF Greece, are not organized and regulated on the basis of a formal (participatory) structure, but rather at personal level.[55] Particularly, during the course of their action these organizations have created unofficial networks of (specialist) physicians for providing their services (i.e., free access to adequate care and hospital referrals) on a voluntary basis by means of co-operation across Greece.[56] At this point, it is essential to stress that members of the medical profession, working in the public sector (i.e., state officials), in case they are caught to provide more than emergency medical care to undocumented migrants, are disciplinary and criminally liable due to the infringement of their duties pursuant to prior Article 84 § 4 of Law 3386/2005 and Article 26 § 4 of Law 4251/2014.[57] This might explain why the NGOs have tended to avoid developing formal mechanisms in preference for mechanisms primarily based on interpersonal relationships, as aforementioned.

Meanwhile, given the potential threats to individual and population health the NGOs have in several instances voiced their concerns about the limited access to health care granted to undocumented migrants (section 7.3.3).[58] Indeed, such organizations can help to raise awareness by means of information campaigns and

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54 Médecins Sans Frontières, *Medical Assistance to Migrants and Refugees in Greece*, Greece: MSF 2013; Médecins Sans Frontières, *Critical Conditions within the Detention Centers*, Greece: MSF, <http://www.msf.org>

55 See as to the process followed by respective NGOs to achieve their goals: Website <http://mdmgreece.gr/en/statute-resources/>; Website <http://www.msf.org/en/about-msf/msf-charter-and-principles>; European Union Agency for Fundamental Rights, '*Migrants in an irregular situation: access to healthcare in 10 European Union Member States',* Luxembourg: Publications Office of the European Union 2011, pp. 30-31.; Note also that the Greek State has not developed a firm legislative framework to regulate and supervise the activities of NGOs.

56 Ibid.

57 Ibidem supra note 33.

58 Ibidem supra note 53, p. 2. For instance, Médecins du Monde prepared and addressed a petition for signing to European health professionals, asking them to take a position on the limited access to health care for undocumented migrants by stipulating that they will not deny treatment to patients on any basis. Consequently, the petition was signed by 147 health professional bodies and submitted to the European Parliament.

strategies that involve health professionals, community leaders and citizens as to the long-term health consequences of such State legislative measures.[59] Ultimately, the active participation of civil society as a way of identifying health-related solutions and of combating exclusion of this vulnerable group will exert social pressure for political commitment against inhuman and degrading treatment of undocumented migrants and for State compliance with its treaty obligations.[60] Thereby, such participatory initiatives could lead not only to the alteration of national laws and policies, but also to the reinforcement of solidarity within the Greek society.

7.3.6. REMAINING ISSUES

The lesson to be drawn from the above analysis is that the recognition of an entitlement to health (care) for undocumented migrants does not automatically imply that this specific population group will obtain access to the same extent of health care and under the same conditions as Greek nationals. The constitutional referral to the term *citizens* in relation to the State's duty to provide health care in Article 21 § 3 in connection with access to mere emergency medical treatment for undocumented migrants generally creates a tension with the human rights framework. In particular, such developments raise issues of great concern in light of the State's compliance with the AAAQ framework, which, *inter alia*, requires that health care must be accessible to all without discrimination, as will be further elaborated below. Importantly, the CESCR has noted with concern in its 2015 report for Greece that undocumented migrants 'encounter difficulties in gaining access to health-care facilities, goods, services and information (art. 12)'.[61] Here, it is essential to mention that while the concluding observations of the UN treaty monitoring bodies, like CESCR, are not legally binding, they tend to provide some authoritative material for underlining that Greece, in order to comply with its right to health obligations, must meet the specific and distinctive health needs and interests of undocumented migrants.

When looking at the availability of health care services for undocumented migrants, the CESCR has emphasized that the Greek State should ensure that undocumented migrants and their members of their families have access to basic health care, including health examinations upon their arrival in Greece as well as

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[59] Ibid.

[60] For instance, Médecins du Monde Greece developed a project called '*Enough!*' in collaboration with the Greek Council for Refugees with the aim of reacting against the rise of xenophobia in Greek society, <http://www.mdmgreece.gr>.

[61] UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 35.

the availability of translation services and information on health-care services whose lack is also a cause for concern regarding the quality of care given to these migrants.[62] In practical terms, this means that the Greek State should strive to provide holistic health care, namely beyond the provision of solely emergency medical treatment, to undocumented migrants, including preventive treatment (early diagnosis and medical follow-up), child immunization, prenatal and neonatal care, and dental care in conformity with the broader understanding of the right to health primarily under Article 12 ICESCR as well as Article 5 § 5 of the Constitution of Greece (see Part I, section 4.2.3).[63] Instead, over the years under respective law provisions the Greek State has explicitly denied these people the right to preventive and almost all palliative health care with the exception of when their medical condition has reached the phase of emergency care which is permitted by law (see section 7.3.3).[64] In light of the limited access to health care, undocumented migrants with chronic diseases (e.g., asthma, diabetes, HIV/AIDS etc.) are formally excluded from accessing adequate health care as well as all forms of necessary preventive and curative health care (chronic disease management) and, consequently, they are deprived of their right to health (care) with serious effects to their well-being in the long-term. This situation raises concern in light of the principle of 'availability' under the 'AAAQ' and requires some considered and systematic attention on the part of the Greek State.

Specifically, this essential element of 'availability' under the 'AAAQ' requires due attention especially regarding undocumented migrant women and children who constitute particular vulnerable population groups as they are exposed to a greater extent than men to the possibility of deteriorating health due to their legal status and to their special health needs associated to gender, age and dependency upon the decisions of others. As such, when it comes to access to health care for undocumented migrant women, the Greek State must give attention to the provision of gender-specific care, namely maternal health care (pre-natal as well as post-natal care) to all women, irrespective of their status primarily pursuant to the CEDAW, which is binding for Greece. However, the prevailing practice, namely

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62 Ibid., UN CESCR, CO: Greece 2015, § 36(c).

63 The UN CESCR under § 34 of its GC No. 14 (supra note 21) on the right to health underlines that '[i]n particular, States are under the obligation to *respect* the right to health by, *inter alia,* refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy…'.

64 Ibidem supra note 33.

the limited access to health care for this vulnerable population group, constitutes a questionable development given that this state practice is not in accordance with Article 24 § 2 (d) CRC and Article 12 § 2 CEDAW (see Part I, section 2.2.2), which are both binding for Greece.[65] As a consequence, pregnant undocumented migrant women do not receive prenatal care and only seek medical attention on the day of delivery. Meanwhile, the European Parliament, repeatedly acknowledging the prevailing restricted policies for undocumented migrant women among EU Member States, like Greece, in its 2011 and 2014 resolutions, while not having strictly binding status, draws attention to the promotion of public policies that aim at gender-specific health needs of undocumented migrant women. In particular, the European parliament calls EU Members States, like Greece, to ensure sufficient access to reproductive and maternal health care, including safe motherhood, and the protection of all (pregnant) women regardless of their status.[66]

As regards to undocumented migrant children, the respective law provisions recognize (in principle) that children must be medically treated irrespective of their legal status or that of their parents. Here, the Greek law is consistent with its treaty obligations as these children are explicitly via law entitled the same care as legal migrants and Greek nationals (see section 7.3.4). Such an approach is, also, adopted in the case law of the ECSR, which has, *inter alia*, focused on the position of children of illegally residing migrants and provides some useful insights with regard to their entitlement to health care. In fact, the Committee has pointedly noted that mere emergency medical care is not considered sufficient for this vulnerable group (see Part I, sections 2.3 and 4.3).[67] Nevertheless, it is notable that the provision of care to undocumented migrant children starting as from their birth is not explicitly addressed by the respective law provisions. Considering this, one perceives the possible tension created with the principle of 'availability'.

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65 See Annex 2.

66 Ibidem supra note 2, European Parliament resolution 2011, §§ 21 and 22; European Parliament resolution of 4 February 2014 on Undocumented Women Migrants in the European Union, (2013/2115 (INI)), §§ 9 and 10; Note that WHO provides guidance to States as to the processes and the practical measures to be developed with a view to ensuring the provision of appropriate pre- and post-natal care to all women (WHO, *Standards for Maternal and Neonatal Care*, Geneva: World Health Organization 2007).

67 See, e.g., *International Federation of Human Rights Leagues (FIDH) v. France* (Complaint No. 14/2003, 3 November 2004) §§ 36-37 - Notably, the ECSR found a violation of Article 17 (Revised) ESC which provides an expansive protection (social, legal and economic protection) with respect to children; *Defence for Children International (DCI) v. Belgium* (Complaint No. 69/2011, 20 November 2012) § 152- The ECSR found a violation of Articles 11(1) and (3), and 17 (Revised) ESC.

In light of the principle of accessible health care without discrimination, which is one of the components of accessibility, it requires considered attention that the Greek State, through its law and policy, regulates access to health care for undocumented migrants upon the migration status (i.e., regular or irregular migration status), except from undocumented migrant children (whether accompanied or not).[68] This has led to limited access to health care for this vulnerable group, namely only to situations which involve an immediate threat to life. This also means that in virtue of the lack of legal status, undocumented migrants cannot enroll for health insurance schemes and as such, they seek informal channels of health care. This, however, in addition to the persistent health sector corruption (i.e. under the table payments), as observed in chapter 6, renders them more vulnerable to exploitation and increased health risks, in that it becomes even more difficult for them to access health care in Greece. As a result, such cases which are not regulated upon medical criteria (i.e. health status and health needs of discrete groups) raise concern in light of the aforementioned principle. Indeed, the CESCR in its 2015 report for Greece was concerned about 'the persistent discrimination against persons with immigrant backgrounds', especially in health care.[69]

Another issue of high concern is economic accessibility (i.e., affordability of care), primarily as regards to undocumented migrants with chronic diseases, undocumented migrant (pregnant) women and children who require more care than others throughout their lives and often lack required financial resources due to high rates of poverty and lack of employment etc. In such cases, when care is available, costs associated with accessing this care, including increased user fees and high prices in medicines, constitute a significant barrier to such care. This could imply that these groups of patients are confronted with an excessive financial burden that threatens their affordability of health care and ultimately affects adversely their health status. For example, in cases of pregnancy, undocumented migrant women may give birth at full cost, as this matter is not addressed explicitly by the respective law (see section 7.3.3). This financial

[68] Note that such a practice is in conjunction with Article 13(4) of the RESC, which is binding for Greece and provides equality of medical treatment on the grounds of the legality of an individual's presence. (Revised European Social Charter (RESC), 3 May 1996, entered into force 1 July 1999, E.T.S. 163) - Greece ratified and incorporated the Revised ESC by Law 4359/2016 (Annex 2). Nonetheless, it is worth noting that although the rights in the (revised) ESC, in principle, are granted solely to persons lawfully present within contracting Member States, the case law of ECSR is gradually expanding the scope of the respective provisions with regard to undocumented migrant children (see supra note 67).

[69] Ibidem supra note 61, UN CESCR, CO: Greece 2015, § 9.

burden could lead a number of undocumented migrant women in labor to seek unacceptable and risky solutions, such as to give birth at home primarily without medical support, which increases the risks of complications at birth and of deteriorating both the health of the mother and the newborn. It is on this basis that the CEDAW Committee expressed its concern in its concluding observations for Greece and urged Greece to adopt measures with a view to ensuring that this group has sufficient access to available health care.[70] Particularly, the Committee has drawn attention to the social exclusion and vulnerability of this group in conjunction with 'the obstacles preventing them from enjoying basic rights such as access to health-care services …'.[71] As such, the Committee recommended 'that the State party (a) takes all necessary measures to improve the economic situation of disadvantaged groups of women, thereby eliminating their vulnerability to exploitation, and to improve their access to health-care services and social benefits, irrespective of their status…'.[72]

When looking also from the perspective of economic accessibility, another issue of concern arising is that in practice there is an apparent contrast between the legal provisions that recognize the same rights to health as Greek children and the prevailing policies that create obstacles to treatment of undocumented migrant children, such as the high costs of health care and could be prejudicial to their health.[73] In other words, there is an apparent gap between the law and the living reality of these children, as the Greek State fails to translate its right to health obligations in accordance with the socio-economic reality in which these children and their families live, namely fails to ensure affordable care to these children and their families. On this basis, the Greek State has repeatedly received critique from the CRC Committee, as already mentioned.[74] Even so, it is worth noting that no

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70 UN CEDAW Committee, CO: Greece, UN Doc. CEDAW/C/GRC/CO/7, 1 March 2013, §§ 32 and 33(a).

71 Ibid., § 32.

72 Ibid., § 33(a).

73 Notably, the ECtHR has ruled that a State owes a duty to take adequate measures to provide care and protection for all children as part of its positive obligations under Article 3 ECHR. Thereby, inadequate care and protection of children, especially in cases of unaccompanied children due to their increased vulnerability, may amount to inhuman treatment pursuant to Article 3 ECHR. See, *inter alia*, *Mayeka and Mitunga v. Belgium* (Application no. 13178/03), ECtHR 12 October 2006, §§ 50, 53, 55, 58, 69; *Rahimi v. Greece* (Application no. 8687/08), ECtHR 5 April 2011, §§ 33, 87.

74 Ibidem supra notes 47 and 48; See, for an analogous approach, e.g., UN CRC Committee, General Comment No. 3: *HIV/AIDS and the rights of the child*, UN Doc. CRC/GC/2003/3, 17 March 2003, § 21. Accordingly, the CRC Committee stressed that State parties must

individual is entitled to receive any type/form of health care free of charge in all circumstances.[75] Nevertheless, the Greek State should create favorable environments for the enjoyment of the right to health (care) through the functioning of its health system and health insurance schemes,[76] bearing in mind that good individual health is also to the benefit of the public, in that individuals with certain diseases (i.e., communicable diseases) constitute also a threat for others (see below section 7.4.2).

In addition to the serious concerns raised with regard to the 'AAAQ' requirements, participation and accountability, important elements of the right to health framework (see Part I, section 3.5) are not given considerable attention on the part of the Greek State in the formulation, implementation and assessment of health-related law and policies for undocumented migrants. Particularly, this can be illustrated when looking at developments-policies that link access to health care with immigration control, involving detention and expulsion of undocumented migrants with life-threatening conditions, compulsory medical testing, as will be further elaborated in section 7.4. Considering such questionable developments, the Greek State should ensure the establishment of participatory and accountability mechanisms sensitive to the undocumented status of this population group, namely mechanisms that are easy for them or for their representatives to access without fear of sanctions. Importantly, in many cases the fear of sanctions, namely the fear of being caught, detained and deported serves as a deterrent for undocumented migrants to file a complaint about malpractices or to report substandard care.

Significantly, it also became evident that while the Greek State has the primary and overall responsibility, in practice a number of NGOs have assumed greater role in realizing the right to health (care) for undocumented migrants in Greece through informal social protection structures that run parallel to the State (see section 7.3.5). At the same time, such development, though, constitutes a serious cause for concern, in that the Greek State might decide to absolve itself from its ultimate responsibility for realizing the right to health (care) for undocumented migrants given its hardly manageable costs of healthcare, scarcity of resources and large irregular migration flows. All in all, one may agree with the argument that the 'virtual exclusion of

'sufficiently take into account differences in gender, age and the social, economic, cultural … context in which children live' in the design and development of health-related policies.

75 K. Tomaševski, 'Indicators', in: A. Eide, C. Krause and A. Rosas (eds), *Economic, Social and Cultural Rights. A Textbook*. 2nd revised ed. Dordrecht/Boston/London: Martinus Nijhoff Publishers 2001, pp. 531-543, p. 543.

76 Ibid.; A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, Volume 5(4), pp. 389-408, p. 401.

illegals would appear to confirm that the present state of human rights focuses on citizens, and, rightly, tries to be accommodating to non-nationals, as long as they are lawfully present'.[77] Indeed, in Greece, irregular migration is a constantly pressing issue and the Greek State uses health care more as a mechanism, serving migration control reasons, namely discouraging the future entry of migrants in an irregular situation, rather than considering it from a right to health perspective.

Last but not least, given the 5-yearly economic crisis and the increasing attention to undocumented migrants within the EU, the Greek State needs to co-operate intensively with other EU Member States (in terms of solidarity and responsibility sharing among the States) as well as with international organizations (e.g., WHO) on the fulfillment of its right to health obligations for undocumented migrants (see Part I, section 4.4).[78] In this respect, a constructive dialogue and combined efforts are required for the adoption of a set of clear and practical implementation measures targeted to the distinctive health needs of undocumented migrants at the national and European level that will contribute to the effective implementation of these obligations within its jurisdiction.[79] Being perhaps the most striking example, on 20 and 21 April 2015 in an informal meeting the Ministers of Health of Greece, Italy, Malta and Cyprus addressed the significance of the inclusion of the health dimension in the European agenda for migration especially due to the growing irregular migratory flows in the Mediterranean countries of the EU. This initiative of the four Ministers of Health aimed at increasing awareness of the health dimension of migration as well as of shared responsibility, namely of a need for co-operation and collaboration among EU Member States in this regard and of adoption of a common approach to address health-related challenges posed by increasing irregular migration.[80]

7.4. AREAS OF CONCERN AND STEPS FORWARD

In essence, the Greek experience illustrates the challenges when a country tends to abide by its right to health obligations -albeit not in a concrete manner- for every individual, including undocumented migrants, while at the same time tries to control the high influx of irregular migration and the rising costs of its health care.

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77 P. Van Krieken, 'Health and continued residence: reason or pretext' *European Journal of Health Law* 2000, 7(1) pp. 29-46, p. 35.

78 Ibidem supra note 61, UN CESCR, CO: Greece 2015, § 12.

79 UN Special Rapporteur, Crépeau (infra note 105), §§ 84 and 118.

80 General Secretariat of the Council, *Employment, Social Policy, Health and Consumer Affairs Council meeting on 18 and 19 June 2015 - The importance of the health dimension in the European Agenda on Migration,* Brussels: Council of Europe, Doc. 9479/15, 4 June 2015.

When it comes to undocumented migrants, the effective enjoyment of their right to health (care) is being challenged by state actions and policies, which signal dangers for the individual and population health. Notably, as will be subsequently elaborated, the right to health of undocumented migrants is reinforced and supported by other rights which address integral components of the right to health and have notable right to health implications (see Part I, section 2.5).[81] These rights in conjunction with the right to health oblige the Greek State to enhance the position of undocumented migrants by meeting their diverse health needs and provide them an unimpeded access to health care. Thus, particular areas of concern, which may threaten the objectives of the right to health and are also pointed out by respective human rights bodies, coupled with steps forward will be highlighted below.[82]

7.4.1. EXPULSION OF SERIOUSLY ILL UNDOCUMENTED MIGRANTS

The way under which a migration law is enforced and applied has a direct impact on whether undocumented migrants with serious health care needs will receive appropriate medical treatment. A cause for concern from a human rights perspective is the expulsion of undocumented migrants with serious health problems by the Greek authorities. Article 19A § 2 (e) of Law 4251/2014 provides that a residence permit may be issued on humanitarian grounds to third-country nationals with serious health problems.[83] However, preconditions of such a permit are that the applicant should obtain a strong residence permit, indicative of his or her legal status, and a recent medical certificate. The medical certificate should clearly address the immediate need for medical or surgical treatment (health status), which cannot be deferred without prejudice to the applicant's health as well as the duration of such treatment. This means that an individual with serious health problems may be expelled to his or her country of origin if he or she does not fulfill both of the two aforementioned requirements.

At this point, it is essential to mention that the aforementioned law provision

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[81] Ibidem supra note 21, GC No. 14, § 3.

[82] See, e.g., Ibidem supra note 61, UN CESCR, CO: Greece 2015, §§ 12 and 35 as well as respective Reports of two UN Special Rapporteurs on the right to health (UN Doc. A/HRC/4/28/Add.2) and on the human rights of migrants (UN Doc. A/HRC/23/46/Add.4) respectively, where the Rapporteurs have occasionally voiced their concern about the respective challenges that are discussed in the context of Greece in section 7.4.

[83] Ibidem supra note 33. As added by Law 4332/2015, Article 8 § 25, *Official Government Gazette,* ΦΕΚ issue Α′ 76/09-07-2015. The duration of residence permit is two years which may be extended every two years on condition that the applicant continues to fulfill the requirements under the respective law.

should be read in conjunction with Article 37 § 4 (a) of Law 2910/2001, where it is explicitly stressed that undocumented migrants cannot receive a temporary residence permit for medical reasons if they have entered the country illegally. Consequently, those migrants are not entitled to obtain an expulsion delay for medical reasons, as their petition to the respective authority can be considered inadmissible.[84] Meanwhile, the aforementioned law provisions and the ensuing state decisions can be a cause for concern, as they do not integrate considerations about the availability of a required treatment in the undocumented migrant's country of origin as well as the accessibility of the treatment to the particular individual in question. As a result, these developments have significant right to health implications (see Part I, section 3.5), as they are inconsistent with the individual's right to health.

At the same time, the denial of health care combined with the expulsion of undocumented migrants has, also, been considered to be in conflict with the prohibition of inhuman and degrading treatment. In fact, the expulsion of a seriously ill undocumented migrant to his or her country of origin and exclusion from essential healthcare treatment may amount to inhuman or degrading treatment and, thereby, may constitute a violation of Article 3 ECHR, which is legally binding for Greece.[85] Indeed, there are several decisions of the ECtHR about whether the expulsion of an alien with a life-threatening illness would constitute inhuman or degrading treatment in the event that treatment was unavailable in the country of origin.[86] In this respect, the ECtHR in the landmark case of *D. v. the United Kingdom* (1997) pointed at the distressing conditions under which expulsion of a severely ill non-national and that these could constitute a breach of the prohibition of inhuman and degrading treatment under the European Convention on Human Rights (Article 3).[87] Accordingly, the Court noted that the expulsion of a person being in advanced stages of an incurable illness, to his country of origin, where no effective medical or palliative treatment for his illness was available coupled

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[84] As amended by Article 8 § 2 of Law 3146/2003, *Official Government Gazette*, ΦΕΚ issue Α′ 125/23.5.2003.

[85] Article 3 ECHR (4 November 1950, ETS 5) stipulates that 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'. The ECHR was incorporated with Legislative Decree 53/1974, *Official Government Gazette*, ΦΕΚ issue Α′256/20-09-1974.

[86] See, e.g. *N. v. the United Kingdom* (Application no. 26565/05), ECtHR 27 May 2008; *Salkic and Others v. Sweden* (Application no. 7702/04), ECtHR 29 June 2004, p. 10; *Ndangoya v. Sweden* (Application no. 17868/03) ECtHR 22 June 2004, p. 13; *Arcila Henao v. the Netherlands* (Application no. 13669/03), ECtHR 24 June 2003, p. 8; *Bensaid v. the United Kingdom* (Application no. 44599/98), ECtHR 6 February 2001, § 38.

[87] *D. v. the United Kingdom* (Application no. 30240/96) ECtHR 2 May 1997, §§ 49-54.

also with the lack of accommodation, family, moral or social support, mainly exposing him to the risk of dying, would amount to inhuman treatment. However, the Court emphasized the exceptional circumstances of such a case.[88] The Court, thereby, is rather hesitant to engage such a positive state obligation under the Convention concerning the non-expulsion of a seriously ill individual to his or her country of origin, where the available health care is less favorable than those already enjoyed in the host country; and it may result in the deterioration of his or her condition, without, though, his or her illness reaches a terminal stage (i.e., imminent death or serious physical and mental suffering).[89]

Lastly, in terms of consistency with the right to health framework (see Part I, section 3.5) when judging an expulsion of a seriously ill undocumented migrant, Greek authorities must give special and more considered attention to the level of availability and accessibility to appropriate health care in the country to which the individual is to be returned, pursuant to the specific state of health of the individual (i.e., in the context of progression of the illness and possible complications). Otherwise, the Parliamentary Assembly of the Council of Europe has cautioned - in an effort to guide the coordination of national legislations and policies in a non-binding manner- that the expulsion of a seriously ill migrant will amount to a 'death sentence' for that person.[90]

7.4.2. PUBLIC HEALTH ISSUES RELATING TO UNDOCUMENTED MIGRANTS

The regulation of access to health care upon the migration status combined with the imposition of (arbitrary) detention measures on the part of the Greek State has raised issues of concern, in that the respective law provisions and practice do not take into account the right to health perspective and create tension with the human rights framework. In Greece it appears that concerns about public health issues often underlay several strict policy decisions-measures on the part of the Greek State. Indeed, in response to the growing concern with respect to public health interests due to an HIV outbreak since the beginning of 2011 in Greece, the Greek

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88 Ibid., §§ 49 and 54; See Part I, section 2.3 ('*3 European Convention for the Protection of Human Rights and Fundamental Freedoms')* for the approach adopted by the ECtHR in similar cases.

89 Ibidem supra note 87.

90 Report 13391 of the Committee on Migration, Refugees and Displaced Persons of the Parliamentary Assembly of the Council of Europe on 'Migrants and refugees and the fight against AIDS', 2014, p. 3.

State issued Health Regulation YA GY39a/2012[91] and Article 59 of Law 4075/2012.[92] Accordingly, Article 59 of Law 4075/2012, in conjunction with Article 1 of the YA GY39a/2012 Health Regulation, provides for individuals, including undocumented migrants, to be detained and compulsory treated for reasons of safeguarding public health interests. Pursuant to the regulation, as a priority of forcible testing and isolation are considered cases that represent 'a danger to public health'; 'suffer from infectious diseases'; 'belong to groups vulnerable to infectious diseases, especially because of the country of origin'; or live in 'conditions which do not comply with the minimum standards of hygiene'.[93] Meanwhile, concerns were expressed about the extent of compatibility of such legislative provisions with human rights law as well as with the Constitution of Greece by several human rights organizations (Part I, section 4.2.3).[94] In fact, the provisions of the YA GY39a/2012 Health Regulation and Law 4075/2012 (Article 59) require the imposition of compulsory medical examination (i.e., obligatory even non-consensual HIV testing) and treatment; and the use of mandatory detention solely justified on the basis of an indication of a health risk. When considering the underlying rationale for mandating compulsory treatment and the process followed by the Greek State, namely that this policy is performed without informed consent (failing to respect the rights to autonomy, dignity and confidentiality of health information), we can conclude that this policy is incompatible with health-related human rights standards, including the right to health, and constitutes a human rights breach (see Part I, section 3.5 and Part II, section 6.4.3).[95]

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[91] 'Provisions on the Restriction of the Spread of Infectious Diseases', *Official Government Gazette* - ΦΕΚ issue Β′1002/02-04-2012. The regulation lists several diseases of public health importance, including influenza, tuberculosis, malaria, polio, syphilis, hepatitis, and HIV.

[92] Article 59 of Law 4075/2012 amended Article 13(2) of the Presidential Decree 114/2010 and Article 76 (1) (d) of Law 3386/2005; See, also supra note 50. Accordingly, a 57% increase in 2011 in the number of HIV/AIDS cases was reported combined with a high increase in the number of people dying of HIV-AIDS from 2007-2009.

[93] Ibid.

[94] See, e.g., Joint United Nations Programme on HIV/AIDS (UNAIDS), *UNAIDS urges Greek authorities to repeal Sanitary Decree- Press Statement.* Accordingly, the UNAIDS requested for the repeal of the law as it 'could serve to justify actions that violate human rights'. http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2013/july/20130731greece/; Ibidem infra note 105, § 44. Accordingly, the Special Rapporteur on the human rights of migrants noted that 'these measures are discriminatory and target the most vulnerable migrants, and that they will lead to even more stigmatization'.

[95] For instance, as regards the consent of the patient this practice is not in accordance with Article 5 of the Biomedicine Convention, which is legally binding for Greece. Note that the

In January 2005, the ECtHR in the case of *Enhorn v. Sweden* set out the essential criteria for the justification of the detention of a person 'for the prevention of the spreading of infectious diseases'. Accordingly, with regard to the criteria, the Court stressed that attention should be given on whether the spreading of an infectious disease is dangerous to public health or safety, and whether the detention of the person infected is the last resort in order to prevent the spreading of the disease. It, further, noted that the less severe measures should be considered first before applying more restrictive ones, such as detention.[96] Thereby, beyond considering the short-term outcomes of State health interventions, attention to human rights law can offer some guidance on how such interventions should be implemented in order not to threaten both the rights of individuals and public health in the long-term (see Part I section 3.5).[97] It is incumbent on the Greek State to strike the right balance between the need to protect individual rights (e.g., physical integrity, privacy) and the health of the general population-public interests (see Part I, section 3.3). For instance, the Greek State, instead of imposing mandatory (non-consensual) medical testing and arbitrary detention measures for undocumented migrants could increase availability of high-quality voluntary counselling services; anonymous routine HIV-testing and treatment provided within the ESY infrastructure, as a health-care continuum; and develop awareness-raising programmes.[98] Indeed, the European Centre for Disease Prevention and Control (ECDC) in its HIV testing guidance pointedly asserted that (undocumented) migrants, especially coming from countries with high HIV prevalence, should be offered an HIV test, which should be voluntary, confidential and conducted after previous informed consent.[99]

Meanwhile, another issue of concern from a right to health perspective is the poor conditions of the mandatory detention of migrants irregularly entering Greece, including unaccompanied children and families. In fact, the poor detention conditions for irregular migration in Greece have been repeatedly brought before

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Biomedicine Convention has become integral part of the national law under Law 2619/1998, (see Annex 2).

96 *Enhorn v. Sweden* (Application No. 56529/00) ECtHR 25 January 2005, § 41.

97 S. Gruskin & D. Tarantola, 'Health and Human Rights' in: S. Gruskin, M.A. Grodin, G.J. Annas & S.P. Marks (ed.), *Perspectives on Health and Human Rights*, New York and London: Routledge 2005, pp. 3-57, p. 43.

98 Ibidem supra note 21, GC No. 14, §§ 28-29.

99 European Centre for Disease Prevention and Control, *ECDC Guidance. HIV testing: increasing uptake and effectiveness in the European Union,* Stockholm: ECDC, December 2010.

the ECtHR which has made decisions and declared cases admissible under Article 3 ECHR, whose respect (or not) has implications on the enjoyment of the right to health and ultimately on undocumented migrants' state of health.[100] Particularly, on several instances the Court has pointedly noted that the appalling conditions in the detention centers in Greece, which do not secure the health and well-being of individuals, can amount to degrading treatment and, thus, may constitute a violation of Article 3 ECHR.[101] In fact, in 2011 in the case of *M.S.S. v. Belgium and Greece* it was ruled that Greece did not comply with the minimum standards of treatment (e.g. several sanitary and hygiene problems) and, as a consequence, undocumented migrants who travel from Greece to other European countries cannot be returned to Greece - the point of entry - which is the procedure normally followed under EU law, namely under the Dublin II Regulation.[102] Additionally, in the case of *M.S.S. v. Belgium and Greece* the Court in its ruling acknowledged the difficulties that Greece experiences, mainly the economic pressures and the heightened influxes of migrants, without, though, absolving the Greek State from its obligations under Article 3 ECHR.[103]

In response to the criticism, Greece adopted new legislation, namely Law 3907/2011, which, *inter alia*, specifies the establishment of Initial Reception Centers for undocumented migrants, who have illegally entered the country, and regulates issues related to the fulfillment of their basic needs, involving the provision of medical care, psychosocial support etc.[104] However, since the enaction of the

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[100] See, e.g., *M.S.S. v. Belgium and Greece* (Application no. 30696/09) ECtHR 21 January 2011; *B.M. v. Greece* (Application no. 53608/11) ECtHR 19 December 2013; *De los Santos and de la Cruz v. Greece* (Application nos. 2134/12 and 2161/12) ECtHR 26 June 2014; *S.D. v. Greece*, (Application no. 53541/07), ECtHR 11 June 2009.

[101] See, e.g., ibid., *M.S.S. v. Belgium and Greece,* §§ 221-222 & 263-264; *S.D. v. Greece*, §§ 49-54.

[102] Ibid., *M.S.S. v. Belgium and Greece,* §§ 222 & 339-340 read in conjunction with § 368.

[103] Ibid., *M.S.S. v. Belgium and Greece,* §§ 223-224; With respect to the poor detention conditions of children, see, *Rahimi v. Greece* (Application no. 8687/08), ECtHR 5 April 2011, §§ 33, 87 and 104 -106. Accordingly, the ECtHR held that the detention conditions, particularly concerning the accommodation, hygiene and infrastructure, had been so severe as to undermine the very meaning of human dignity and that the Greek State owed a duty to take adequate measures to provide care and protection as part of its positive obligations under Article 3 of the Convention.

[104] Law 3907/2011, *Official Government Gazette* – ΦΕΚ issue Α′ 7/26-01-2011, on the 'Establishment of the Asylum Service and the Initial Reception Service, adaptation of the Greek legislation to the provisions of Directive 2008/115/EC (EU Returns Directive) on common standards and procedures in Member States for returning illegally staying third-country nationals, and other provisions'. Of note, this legislative initiative taken by the

respective legislation, the conditions in the detention centers in Greece were not significantly improved due to weak law enforcement, which was also identified by the UN Special Rapporteur on the human rights of migrants, François Crépeau, during his official visit to Greece in 2012.[105] Moreover, as regards to the health status of the undocumented migrants under detention, Crépeau noticed that 'the majority of the medical problems migrants in detention suffer from are caused by, or directly linked to, their detention conditions in Greece'.[106] Indeed, given the poor detention conditions (i.e., lack of basic hygiene, water and quality food) and the fact that detention centers are often overcrowded, the transmission of contagious diseases is facilitated, thereby putting at extremely high risk not only the health of this group, but also the health of the general population.[107] At the same time, Crépeau expressed concern about the availability and quality of the medical treatment in the detention centers by stressing that 'the medical services offered in some of the facilities by KEELPNO (Hellenic Centre for Disease Control and Prevention) were highly insufficient. Some of the detention centers had no permanent medical staff, and relied on daily visits by KEELPNO only'.[108] Added to the above, it was brought to his attention that detained undocumented migrants, who suffered from several health problems, had not received appropriate medical treatment. As such, he emphasized the need for specialized staff in each detention facility, such as doctors, nurses, psychologists, social workers and interpreters.[109] Last but not least, he called on the Greek State to operationalize law 3907/2011 and enhance detention conditions by, *inter alia*, ensuring that 'all detained migrants have access to proper medical care, an interpreter, adequate food and clothes, hygienic conditions…'.[110] All in all, such expressions of concern and calls for action (i.e., covering both access to health care and access to the underlying determinants of health) are considered to offer some principal guidance as to the process (practical measures) required by the Greek State (see Part I, section 4.2.3)

Greek State was welcomed by the CAT (CO: Greece, UN Doc CAT/C/GRC/CO/5-6, 27 June 2012, § 5).

105 UN, *Report of the Special Rapporteur on the human rights of migrants, François Crépeau, Mission to Greece, HRC, 23rd Sess., Agenda item 3*, UN Doc. A/HRC/23/46/Add.4, 17 April 2013, § 21.

106 Ibid., § 44.

107 Ibid., §§ 49-52.

108 Ibid., § 49.

109 Ibid.; See, also, Medecins Sans Frontieres, *Medical Assistance to Migrants and Refugees in Greece*, Greece: MSF 2013.

110 Ibidem supra note 105, UN Special Rapporteur, §§ 88 and 99(a).

to secure the realization of the right to health of undocumented migrants. At the same time it should be acknowledged that this right is inextricably connected to the enjoyment of other rights (see Part I, section 2.5), notably the right to freedom from inhuman and degrading treatment as found by the ECtHR, and altogether are essential for ensuring individual and population health.

7.5. CONCLUSIONS

Seen from a health and human rights perspective, undocumented migrants, given their particular vulnerable position (primarily on account of the migration process and their clandestine/irregular status) have discrete and special health needs that require systematic and considered (migrant-sensitive) attention in domestic policy-making and legislative actions (see Part I, section 4.2.3). Nevertheless, high levels of influxes of undocumented migrants combined with the increasing costs of health care have led the Greek State to view this particular population group pursuant to its security and economic interests, and as such, to link access to health care with immigration control. Thereto, the Greek State barely considers the implications of the right to health within the adoption of national laws and policies addressed to undocumented migrants and their families in a consistent and coherent way. Certainly, such an approach demonstrates a clear limitation of the enjoyment of the right to health (care) of undocumented migrants. Indeed, for this reason, the CESCR and CRC Committee have repeatedly emphasized that this group should enjoy an unimpeded access to basic health care (see sections 7.3.4. and 7.3.6).

Nonetheless, the measures taken on the part of the Greek State create several obstacles to needed care for undocumented migrants, especially regarding individuals with certain diseases who are also threat for others. While the right to health framework might be imprecise in some respects primarily as to the nature of entitlements to health care for undocumented migrants, it still provides the standards against which national policies should be measured. This study revealed several shortcomings in the provision of health care for undocumented migrants when assessed against the 'AAAQ' requirements. Such disturbing observations illustrate that the Greek State has not effectively and in a systematic manner addressed the implications of 'AAAQ' with the adoption of laws and policies in relation to undocumented migrants. In light of its available resources the Greek State fails to consider the diverse health needs of undocumented migrants and adopt migrant-sensitive policies in line with the living reality (e.g., lack of legal status) of these people (see Part I, section 4.2). By doing so, undocumented migrants become more vulnerable to exploitation and increased health risks. Considering these alarming developments from a right to health perspective, in light of its

available resources the Greek State must acknowledge a minimum level of health care to be available for undocumented migrants (see Part I, section 3.4) and as such it should provide a package of minimum health care services for this group. At the same time the Greek State should also develop a system for the collection of reliable disaggregated data on the situation of undocumented migrants in order to identify their most pressing health needs for policy development and for planning targeted health measures (see Part I, section 3.6). All in all, this means that beyond access to mere emergency medical care, undocumented migrants should not be denied access to (basic) health care and as such they should benefit from disease prevention measures, including early diagnosis and intervention in diseases. Arguably, the implementation of such context-sensitive national health policies, in turn, may enhance individual and population health outcomes.

Meanwhile, it was argued that beyond access to health care the right to health of undocumented migrants cannot be effectively realized without respect for other human rights, which address integral components of the right to health.[111] As was earlier elaborated, the case law of the ECtHR in connection with Articles 3, 5 and 8 ECHR has revealed that other human rights have significant right to health implications, namely play a role in the progressive realization of the right to health of undocumented migrants and in regulating, *inter alia*, an unimpeded access to health care for this group (see section 7.4).[112] It seems that health-related rights (see Part I, section 2.3.1) tend to offer better protection than the right to health itself to undocumented migrants. As such, the Greek State is compelled to acknowledge the interdependence of all human rights within its legal and policy context for undocumented migrants, and reject questionable law-policies that could displace their special health needs by virtue of their legal status. This means that despite budgetary and other considerations (i.e., legal status) the Greek State is required to review the way under which national health interventions for undocumented migrants are being designed and implemented; and to abolish interventions that impose expulsion of undocumented migrants with life-threatening conditions, forcible medical examination and use of mandatory detention. Admittedly, such interventions result in the neglect of the aforementioned human rights, primarily of the right to private life and the right to freedom from inhuman and degrading treatment.

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111 Ibidem supra note 21, GC No.14, § 3.

112 See generally, e.g., A. Hendriks, 'The Council of Europe and Health and Human Rights', in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012.

Furthermore, with respect to the detained undocumented migrants, the Greek State must draw more considered and systematic attention to the poor detention conditions which are a serious cause for concern for individual and population health. By doing, so, the Greek State should ensure that the detained have adequate and regular access to health care, consensual medical check-ups, psychological support, hygiene conditions, as well as enjoy adequate living conditions.[113] Such requirements, at a large extent, constitute the underlying determinants of health (see Part I, section 3.2), which raise significant human rights concerns and therefore they should not remain unaddressed by the Greek State.[114]

All in all, it is crucial that for the right to health of undocumented migrants to be progressively realized, the Greek State must actively assume responsibility. The point to stress therefore is that when the Greek State decides to fully comply with its binding right to health obligations, their operationalisation within national law-policy context could make a positive contribution to the prevailing position of undocumented migrants; by meeting their pressing health needs, while taking into account their vulnerable living reality. In essence, this issue remains in the hands of Greek authorities and will be practically determined at the national level. Even if this appears to be an aspiration given the 5-yearly economic recession, the hardly manageable health care costs and the resource scarcity, it constitutes Greek State's ultimate responsibility. Thus, the most crucial decisions for undocumented migrants are still to be taken and a possible delay of such decisions on the part of the Greek State could lead to severe consequences for undocumented migrants' health and well-being in the long-term.

[113] Ibidem supra note 105, UN Special Rapporteur, § 99(a). For instance, the detainees should have access to appropriate medical care, adequate living conditions, adequate food, hygienic conditions and security, which are preconditions for respecting undocumented migrants' right to health.

[114] Ibidem supra note 21, GC No.14, § 11.

8 Roma Children

8.1. INTRODUCTION

The Roma population represents the oldest and largest ethnic minority in Europe. The number of Roma within Europe is estimated between 10-12 million, of whom around half are EU citizens and around 5-6 million are children.[1] In Greece, the Roma population is estimated around 175,000, though there is no available data on the exact number of Roma who have Greek nationality as well as of Roma children mostly due to their nomadic lifestyle and informal settlement.[2] Meanwhile, the European Commission has pointed out that Roma in Europe encounter considerable impediments in accessing health care combined with the social

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[1] Resolution 1740 (2010) of the Parliamentary Assembly of the Council of Europe on 'the situation of Roma in Europe and relevant activities of the Council of Europe', § 1; <http://ec.europa.eu/justice/discrimination/roma/index_en.htm>;WHO Regional Office for Europe, *Roma Health Newsletter -issue 1*, Copenhagen: WHO, May 2012, p. 1; Report 13158 (2013) of the Committee on Equality and Non-Discrimination at the Parliamentary Assembly of the Council of Europe on 'Ending Discrimination against Roma Children', p. 6 § 2. Of note, the exact number of Roma is difficult to be defined as a large number of Roma families lack official documentation.

[2] European Commission, *The European Union and Roma - Factsheet - Greece*, Brussels: European Commission 2014; See also, ERRC, Submission of the European Roma Rights Centre Concerning Greece for Consideration under the Universal Periodic Review by the United Nations Human Rights Council (HRC) at its 11th Session on 2 – 11 May 2011, p. 1. Accordingly, the ERRC has stressed that based on unofficial estimates Roma in Greece range from 180,000 and 350,000, averaging 265,000 (2.47% of the population in Greece); See, also, Parliament of Greece (Period ΙΕ′ - Synod Α′), *Official Records of Parliament's Session Γ′*, Athens, 25 July 2013, pp.47-50. The Greek Minister of Interior and Administrative Reconstruction stressed that Roma parents are unwilling to register their children either due to ignorance of the birth registration procedure or due to their own negligence and as such there is no available/reliable data to determine the population size of Roma children in Greece.

exclusion, poor living and socioeconomic conditions that they experience in their daily lives.[3] Likewise, UNICEF has pointedly underlined that 'Roma children in all countries across Europe are at risk of experiencing the systematic violation of their rights, reflected in severe poverty and marginalization, discrimination and the denial of equal access to services and of equal opportunities in society.'[4] At a policy level, on 5 April 2011, the European Commission adopted the 'EU Framework for National Roma Integration Strategies up to 2020' and urged all Member States to design or revise national Roma integration strategies in an effort to generate tangible improvements with respect to four key priority areas, *inter alia*, access to healthcare for the Roma.[5]

Importantly, at the same time the ECtHR has recognised in its case-law that this population group has special needs and characteristics by virtue of its both socio-economic and ethnic status which must be given special attention by States in terms of determining and fulfilling their obligations.[6] Particularly, the Court noted that the vulnerable position of this group as a minority means that 'some special consideration should be given to their needs and their different lifestyle both in the relevant regulatory framework and in reaching decisions in particular cases …'.[7] The Court by underlying the particularly vulnerable position of this group in society at large (housing etc.) acknowledged the State's positive obligation to take into account and facilitate the different lifestyle which could entail different treatment for this population group on some occasions.[8]

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3 European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, *An EU Framework for National Roma Integration Strategies up to 2020*, Brussels: European Commission, 5.4.2011 COM(2011) 173 final. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM: 2011:0173:FIN:EN:PDF>

4 UNICEF, *UNICEF and Roma Children*, available at: http://www.romachildren.com/?page_id=437

5 Ibidem supra note 3.

6 See, *Chapman v. the United Kingdom* (Application no.27238/95) ECtHR 18 January 2001; See also, concerning the ECtHR' s awareness of and concern for the way of treatment of the Roma, *Beard v. the United Kingdom* (Application no. 24882/94) ECtHR 18 January 2001; *Coster v. the United Kingdom* (Application no. 24876/94) ECtHR 18 January 2001; *Jane Smith v. the United Kingdom* (Application no. 25154/94) ECtHR 18 January 2001; *Lee v. the United Kingdom* (Application no. 25289/94) ECtHR 18 January 2001. Notably, the above case law reflects also how the ECtHR conceives Roma identity.

7 *Chapman v. the United Kingdom* (Application no.27238/95) ECtHR 18 January 2001, § 96.

8 This approach was also adopted in previous judgments of the ECtHR. In *Thlimmenos v. Greece* (Application no. 34369/97, ECtHR 6 April 2000), the ECtHR stressed that States are obliged to adopt differential measures regarding persons who find themselves in significantly different situations. Specifically, the Court held that 'the right not to be discriminated

Building on the analysis of Part I of the present study and in view of the above concerns and calls for action, in this chapter we will examine whether Greece complies with its binding obligations particularly arising from the internationally guaranteed right to health towards Roma children within the context of health care, although the underlying preconditions for health will also be dealt with where relevant. For this reason, in section 8.3, attention will be drawn to respective national law and policy measures coupled with areas of concern and steps forward in light of the internationally guaranteed right to health. Subsequently, specific challenges relating to socio-economic circumstances, under which Roma children live that are closely intertwined with the effective enjoyment of the right to health in a way that they can be crucial and a decisive factor for Roma children's health and determine their possibilities of accessing health care, will be addressed in section 8.4.[9] But first, in the following paragraph, the definition of two terms, namely Roma and children, as well as the definition of Roma children's health status in Greece will be elaborated.

8.2. ROMA CHILDREN AND THEIR HEALTH STATUS

In general, pursuant to the Council of Europe, the term 'Roma' comprises a wide diversity of population groups, which include Roma, Sinti, Kale and related groups in Europe, such as Travellers and the Eastern groups (Dom and Lom), including also individuals who identify themselves as Gypsies.[10] In Greece, the main groups

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against in the enjoyment of the rights guaranteed under the Convention is also violated when States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different' (§ 44). The reasoning of the Court in Thlimmenos case could be applied to cases relating to other minority populations, such as the Roma.

9 '(…) the fundamental structures of social hierarchy and socially determined conditions that determine how people live, work, are raised and educated, which subsequently determine people's state of health (…)'. WHO/CSDH, *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the commission on social determinants of health*, Geneva: World Health Organization, 2008. <http://www.who.int/social_determinants/the commission/final report/en/index.html>

10 Council of Europe, *Council of Europe - Descriptive glossary of terms relating to Roma issues, version dated 18 May 2012* <www.coe.int/roma>; This definition is used in a number of documents of the Council of Europe, such as Resolution 1740(2010) of the Parliamentary Assembly on the situation of Roma in Europe and relevant activities of the Council of Europe, Committee of Experts on Roma and Travellers (MG-S-ROM). Within the specific 'the European Union and the Roma' section on the European Commission's website it is stressed that 'as it is most commonly used in EU policy documents and discussions, the term 'Roma' here refers to a variety of groups of people who describe themselves as Roma, Gypsies,

of Roma involve: (a) domestic nomadic Roma; (b) long-term settled distinct Roma communities, suffering from poverty and exclusion; (c) long-term settled distinct Roma communities, living almost without problems; (d) Roma migrants who are not EU nationals, especially coming from Albania, but also from Kosovo and the former Yugoslav Republic of Macedonia; (e) Roma migrants from new EU Member States, especially from Bulgaria and Romania; (f) fully integrated Roma who may not even identify themselves as belonging to Roma population; (g) Roma Muslims in Thrace, who benefit from the minority protections pursuant to the treaties between Greece and Turkey following World War II.[11] In addition, even though, Roma in many European countries are generally acknowledged to constitute a minority group, in Greece Roma do not enjoy a special legal status, except for the Roma Muslims in Thrace who are recognised legally as a minority group primarily on religious grounds.[12] Moreover, in Greece, as noted earlier, the Roma population is estimated around 175,000, constituting almost 1,55% of the total population in Greece and living scattered over the entire region with the highest concentrations around large cities, such as Athens and Thessaloniki.[13] The number of Roma children in Greece, though, cannot be estimated due to the lack of appropriate data.[14]

Travellers, Manouches, Ashkali, Sinti and other titles. The use of the term Roma is in no way intended to downplay the great diversity within the many different Romani groups and related communities, nor is it intended to promote stereotypes.' <http://ec.europa.eu/justice/discrimination/roma/index_en.htm>

11 Organization for Security and Co-operation in Europe (OSCE) High Commissioner on National Minorities, *Recent Migration of Roma in Europe*, OSCE and Council of Europe Commissioner for Human Rights, 2nd Ed., October 2010, p. 43; At the CoE level, there is no common definition of the term national minorities. Nonetheless, the Framework Convention for the Protection of National Minorities (adopted in 1994, entered into force in 1998) provides for the protection of minority cultures and identities. In fact, Germany, Sweden and Slovenia make explicit reference to the Roma in their list of minorities located within their borders; Concerning the protection of Muslims in Thrace, see Treaty of Lausanne of 1923, ratified by Greece by the Legislative Decree of 25 August 1923 and Greek-Turkish Peace Treaty, 1 November 1913, ratified by Greece by Law 4213/1913.

12 See, UN CESCR, CO: Greece, UN Doc. E/C.12/1/Add.97, 7 June 2004, §10 read in conjunction with § 51; UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 9; See, Articles 37 et seq. of the Treaty of Lausanne of 1923, ratified by Greece by the Legislative Decree of 25 August 1923.

13 European Commission, *The European Union and Roma – Factsheet -Greece*, Brussels: European Commission, 2014; See also, ERRC, Submission of the European Roma Rights Centre Concerning Greece for Consideration under the Universal Periodic Review by the United Nations Human Rights Council (HRC) at its 11th Session on 2 – 11 May 2011.

14 Ibidem supra note 1, Report 13158, p. 6 § 2; Ibidem supra note 2; UN CESCR, CO: Greece,

Meanwhile, it is worth noting that Greece defines children as all human beings below the age of 18, which is in line with the CRC definition.[15] Importantly, along with the above definition, Greece acknowledges primarily in Articles 1510-1511 of the Greek Civil Code the rights and duties of parents (or other persons legally responsible for the child in Articles 1603 and 1606 of the Civil Code), involving the provision, in a way consistent with the best interests of the child, of appropriate direction in the exercise by the child of the rights as well as their primary responsibility for the upbringing and development of child, which are also in line with Articles 5 and 18 CRC, respectively.[16] These provisions highlight the role of the parents (or other persons legally responsible for the child), in circumstances where a child has not attained capacity and competency, in ensuring the child's rights; *in concreto* as to the right to health (care) these provisions find application in the context of the parents' primary responsibility for ensuring healthy living conditions and guiding the child within health care settings in line with the child's best interests.

Nevertheless, the age and dependence of Roma children upon the status, activities of other people for their growth and development make them more vulnerable compared to members of other age groups with respect to the effective enjoyment of all rights, such as the right to health and health care.[17] At the same time, Roma children are falling also within the category of ethnic minority which contributes to inequalities in relation to health (care) for this group in Greece.[18]

UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 9 (Generally, there is a lack of statistics on the composition of the population in Greece).

15 Article 1 CRC, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3. As at 30 June 2016, 196 States were party to the CRC, including Greece. In particular, Greece has ratified CRC and incorporated into national law by Law 2101/1992; See, Article 121(1) of the Greek Penal Code in conjunction with Article 127 of the Greek Civil Code, which implicitly define a child.

16 Ibid., Articles 5 and 18 CRC.

17 See, preamble and Article 2(2) CRC.

18 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc E/CN.4/2003/58, 13 February 2003, § 66; For instance, the Roma are officially recognized as ethnic minority, *inter alia*, in Austria, Croatia, the Czech Republic, Hungary, Norway, Poland, Romania, Slovakia, Sweden, Ukraine, but not in Greece. On this issue the CESCR has repeatedly expressed concern in its concluding observations to Greece. See, UN CESCR, CO to Greece, UN Doc. E/C.12/1/Add.97, 7 June 2004, § 10 and CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 9-10; The CRC Committee has identified that Roma children, who are repeatedly the subject of concern in its concluding observations, are falling within the category

As such, the combination of age, dependence and ethnicity implies the heightened (double) vulnerability as to their prospects for enjoyment of their right to health (care) as well as the need for the Greek State to adopt context sensitive measures that address the special needs of those children and eliminate obstacles that impede their ability to enjoy their right to health (care).[19]

With regard to the health status of Roma children in Greece this population group face difficulties while accessing health care attributed to a number of factors. These factors include lack of financial means of their families either to pay for health-related costs or health insurance contributions or to afford transportation from remote or isolated areas to health care facilities, lack of identification documents required to obtain health care (see section 8.4).[20] Meanwhile, the fear or the experience of discrimination of Roma children and their families within health-care settings hinders their access to health care and, consequently, weakens their health status.[21] In addition to the insufficient access to health care, many Roma children and their families often experience precarious socio-economic conditions that may have a negative impact on their health, as will be mentioned in section 8.4. As a consequence, Roma children, constitute an extremely vulnerable population group to contracting diseases and developing chronic illnesses and to suffer from poorer health compared to any other population group – the 'average

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of vulnerable children (see Part I, section 4.2.2., *inter alia*, UN CRC Committee CO: Greece, UN Doc. CRC/C/15/Add.170, 2 April 2002, § 56(e), UN CRC Committee CO: Slovakia, UN Doc. CRC/C/15/Add.140, § 35).

19 UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000, §§ 21-22; Ibid., UN CESCR, CO: Greece 2015, § 10; Ibid., UN CRC Committee, CO: Greece 2002, §§ 9-10 read in conjunction with § 56(e).

20 Council of Europe, *The Council of Europe: Protecting the Rights of Roma*, Strasbourg: the Council of Europe's Directorate of Communication in collaboration with the Support Team of the Special Representative of the Secretary General for Roma Issues, September 2011, p. 12; See, UN CESCR, CO: Greece, UN Doc E/C.12/1/Add.97, 7 June 2004, §§ 11 and 15; UN CRC Committee, CO: Greece, UN Doc CRC/C/GRC/CO/2-3, 13 August 2012, § 52; UN CEDAW Committee, CO: Greece, UN Doc CEDAW/C/GRC/CO/7, 1 March 2013, § 32; Note that such cases also exist in other European countries, see, *inter alia*, *ERRC v. Bulgaria*, Complaint No. 46/2007, 3 December 2008. Accordingly, the ECSR found that 'significant cases of discriminatory practices against Roma in provision of medical services' were taken place throughout Bulgaria (§ 50) (see Part I, section 4.3).

21 European Union Agency for Fundamental Rights (FRA), *Data in focus report: the Roma*, Vienna: FRA, 2009. Accordingly, 20% of Roma responded that they had experienced discrimination within health-care settings; See also, UN CESCR, CO: Greece 2015 (supra note 18) and UN CRC, CO: Greece 2002 (supra note 18).

person' among Greece's population. A study carried out by UNICEF revealed that an increasing number of Roma children reported to suffer from avoidable illnesses, such as pneumonia and respiratory illnesses, and skin infections.[22] Over 25% of Roma children are not fully vaccinated, thereby being at a higher risk of contracting vaccine-preventable diseases, which is indicative of their low and insufficient access to preventive care.[23] In general, life expectancy among Roma children is approximately a decade (i.e., about 8-15 years) lower than that of the general population.[24]

As such, attention must be given by the Greek State to the extent of access to health care and to specific areas, including immunization, prevention of transmittable diseases, appropriate treatment of infectious diseases, adequate health care granted to Roma children within national law-policy context. In this regard, in 2011 the European Parliament in its resolution cautioned Member States to design public policies aimed at the promotion of early child development and to ensure that all children irrespective of their status enjoy social protection within their respective jurisdictions.[25]

8.3. HEALTH-RELATED LAW AND POLICY

8.3.1. SETTING THE SCENE

In light of the above analysis and Part I, the state obligations arising from the right to health enshrined in human rights documents that are binding for Greece can provide an important background for its operationalisation in the Greek legislation-policy for Roma children, as they reflect the State's commitment to realize the respective right -albeit dependent upon the particular socio-economic position of Roma children in Greece- (section 8.4).

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22 Ibidem supra note 1, Report 13158, p. 7.

23 Eurostat, *Healthy life years and life expectancy at birth, by sex*, Eurostat, 2013. <http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=TSDPH100>; See, also, European Commission, *Roma Health Report - Health status of the Roma population - Data collection in the Member States of the European Union*, EU, August 2014, p. 43.

24 Greek NGO's network for children rights convention, *Non-Governmental Organizations' Report in Application of the United Nations Convention on the Rights of the Child- Greece*, Athens, April 2011, p. 17; Council of Europe, *The Council of Europe: Protecting the Rights of Roma*, Strasbourg: the Council of Europe's Directorate of Communication in collaboration with the Support Team of the Special Representative of the Secretary General for Roma Issues, September 2011, p. 12.

25 European Parliament resolution of 8 March 2011 on Reducing Health Inequalities in the EU, (2010/2089 (INI)) §§ 21-22.

In order to define respective laws and policies in Greece, it is essential to firstly mention that Roma children either with Greek or other citizenship have exactly the same entitlements to health (care) as the rest of the Greek population, without depending on whether or not they are legally entitled to be in the country. In particular, EU Roma children, namely the members of communities who are citizens of the EU, enjoy the freedom of movement in line with the EU Freedom of Movement Directive 2004/38/CE of 29 April 2004 which establishes the right of EU citizens to move and reside in other EU countries and have the same rights as Greek citizens, including being registered with the National Health System.[26] Further, Roma children who are third countries' nationals, are entitled to receive the same health care under the same conditions as Greek Roma children, whether they reside legally or illegally in Greece, according to Article 26 § 2 (a) of Law 4251/2014.[27]

8.3.2. NATIONAL LEGISLATION REGULATING ACCESS TO HEALTH CARE FOR ROMA CHILDREN

The Constitution of Greece in Article 21 § 1 provides expressly that childhood is under the protection of the State. At the same time, the protection of one's health is also guaranteed under the Constitution of Greece (see section 5.2). Note, however, that the right to health of (Roma) children is not explicitly enshrined in the Constitution, but rather it is located under the umbrella of the general right to health provisions under Articles 5 § 5 and 21 § 3 of the Constitution.[28] Importantly, the Greek law contains several general provisions governing one of the essential elements of the right to health, namely access to health care for vulnerable groups in society, without though explicitly addressing Roma children. This means that access to health care for Roma children in Greece is regulated implicitly by a number of respective law provisions addressed generally to vulnerable groups of the population in Greece.

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[26] European Parliament and the Council of the European Union, *Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States,* April 2004; Note that PD 106/2007, *Official Government Gazette* – ΦΕΚ issue Α′ 135/21-06-2007 (as amended by Article 42 of Law 4071/2012) has integrated at the national level the Directive 2004/38/EC.

[27] Law 4251/2014, *Official Government Gazette* – ΦΕΚ issue Α′ 80/01-04-2014.

[28] The *Constitution of Greece (1975-1986-2001-2008*), as revised by the parliamentary resolution of 27 May 2008 of the VIIIth Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue Α′ 120/27-06-2008.

In particular, Article 1§ 2 of Law 1397/1983, which was discussed elaborately in chapter 6, provides universal access to all citizens, regardless of financial, employment and social status, and as such this provision implicitly, though, reflects the notion under Article 24 § 1 CRC.[29] Moreover, pursuant to Article 44 of Law 2082/1992 Greek nationals and authorized residents with low or no income and without an insurance coverage can obtain a welfare booklet (i.e. as citizens of no financial means) in order to receive cost-free public health care.[30] In addition, Article 3 § 3 (c) of Law 2519/1997 provides for the design and implementation of health programmes addressed to at high-risk population groups with ethnic, social and cultural differences.[31]

Further, Law 3304/2005 underlines the right of every individual to equal treatment, promotes the application of non-discriminatory measures and proscribes any discrimination on any ground (e.g., ethnic, national or racial origin, age), which has the intention or effect of nullifying or impairing social protection, including access to health care.[32] In fact, Law 3304/2005 has integrated at the national level a Council Directive 2000/43/EC of June 2000 (see Part I, section 2.3). Accordingly, it is highlighted that individuals should receive no less favorable treatment irrespective of their racial or ethnic characteristics and that discrimination in the areas of employment, education, social protection, including social security and healthcare, and access to and the supply of goods and services, including housing, is prohibited.[33] In light of the above, it is notable that the guiding principle of non-discrimination does not prescribe a specific level of health care, involving certain services that should be available for children with special health needs, such as Roma children.[34]

Meanwhile, perhaps acknowledging the severe consequences of the continual economic recession on the living reality of many segments of the society in Greece, the Greek State sought to devise solutions on issues involving the high costs of

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[29] Law 1397/1983, *Official Government Gazette* – ΦΕΚ issue Α′ 143/07-10-1983; Annex 2.

[30] Law 2082/1992, *Official Government Gazette* – ΦΕΚ issue Α′ 158/21-09-1992; See also, Joint Ministerial Decision 139491/16-11-2006, *Official Government Gazette*- ΦΕΚ issue Β′ 1747/30-11-2006.

[31] Law 2519/1997, *Official Government Gazette* – ΦΕΚ issue Α′ 165/21-08-1997.

[32] Law 3304/2005 on the 'Implementation of the principle of equal treatment, irrespective of race, nationality, religious or other beliefs, disability, age or sexual orientation', *Official Government Gazette* – ΦΕΚ issue Α′ 16/27-01-2005.

[33] Article 3(1) Racial Equality Directive 2000/43/EC.

[34] A.C. Hendriks, 'Patients' rights and access to health care', *Medicine and Law* 2001, Volume 20, p. 375.

health care mainly for groups with low or no income and without insurance coverage. Importantly, as will be analyzed more fully below, Roma children and their families experience poor conditions with negative impacts upon their prospects for enjoyment of their right to health and health care especially during the economic crisis in Greece.[35] In view of the above concerns, a range of health reform measures regardless of personal economic and employment status were introduced by the Greek State. Specifically, Law 4238/2014, as discussed extensively in chapter 6, provides that every individual, irrespective of financial, social and insurance status, can equally access primary health care system.[36] In line with Law 4238/2014, the Greek Ministry of Health in cooperation with the Greek Ministries of Employment and Finance issued Y4a/GP/oik.48985/2014 and G. P./oik 56432/28-06-2014 decisions, namely two joint ministerial decisions that provide for a cost-free access to hospital and pharmaceutical care, respectively, for individuals and their family members without insurance coverage and ability to afford such coverage (see section 6.4.2.3).[37] The measures regulated by Law 4238/2014 in combination with the respective joint ministerial decisions reflect an effort -belatedly perhaps- on the part of the Greek State to guarantee the economic accessibility of health care for vulnerable groups in society, such as Roma children, which is a significant element of the 'AAAQ' criteria defined by the CESCR in its GC No. 14 on the right to health (see Part I, section 3.5).

Nonetheless, it is worth observing that as elaborated previously (section 6.4.2.3), individuals wanting to benefit from such coverage have to follow a strict and specific procedure that it is not always easy for them to understand how to access its formal structures (i.e. a number of public authorities-committees at different levels) and as such, it remains to be seen as regards to its implications on 'economic accessibility' of vulnerable population groups, like Roma children and their families. At the same time, it is essential to stress that preconditions of such coverage are that the individuals should reside legally in the country and should obtain a social security

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35 UNICEF Office of Research, 'Children of the Recession: The impact of the economic crisis on child well-being in rich countries', *Innocenti Report Card 12*, Florence: UNICEF Office of Research, 2014 p. 9; Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 58.

36 Article 1(3) Law 4238/2014, *Official Government Gazette* - ΦΕΚ issue Α′ 38/17-02-2014.

37 Joint Ministerial Decision Y4a/GP/oik.48985/2014 'Defining the Conditions, Criteria and Process of Access to Health Care for the Uninsured and Financially Weak people', *Official Government Gazette* - ΦΕΚ issue Β′ 1465/05-06-2014; Joint Ministerial Decision GP/oik 56432/28-06-2014, 'Defining the Conditions, Criteria and Process concerning Access to Pharmaceutical Care for Uninsured and Financially Weak People', *Official Government Gazette* - ΦΕΚ issue Β′ 1753/28-06-2014.

number (AMKA).[38] Considering the low rate of birth registration among Roma population (see below, section 8.4.3), such preconditions create a tension with the accessibility principle under the right to health (Part I, section 3.5).

Notably, of particular assistance in setting parameters as to the legislative measures required by the Greek State for the effective implementation of Roma children's right to health (care), are two developments. Specifically, there has been a proliferation of institutional monitoring mechanisms that measure, *inter alia*, the level of implementation of every child's right to health (care), including Roma children in Greece. Particularly, in 2001 the National Observatory on the Rights of Children (NORC) was established under the auspices of the Ministry of Education with the aim of monitoring the implementation of the Convention on the Rights of the Child.[39] This institution has a responsibility to identify problems in the enjoyment of all children's rights and to suggest solutions with a view to securing the effective implementation of state obligations under the CRC. This initiative was welcomed by the CRC Committee in its 2002 concluding observations for Greece as a positive step.[40]

Meanwhile, in 2003 the Greek Ombudsman for Children was established by Law 3094/2003 under the auspices of the general Greek Ombudsman and since 2011 includes a separate investigation team for Roma children issues. Importantly, the duties of this national monitoring mechanism are to promote Roma children's interests to public and private authorities and be a spokesperson for Roma children's rights. Such task involves, *inter alia*, working with local authorities and NGOs in order to ensure that the best interests' principle is respected in the context of State's activities and remains a primary consideration in development of policies by local authorities.[41] All in all, it constitutes an independent authority that can investigate state or private actions or omissions or complaints about individuals or legal entities brought to him by the child itself, its parents/caregivers, or by third parties being aware of violations against the child or on his own initiative. Particularly, this

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38 Ibid., Joint Ministerial Decision GP/oik 56432/28-06-2014, Article 1(1) and (5).

39 Article 4, Law 2909/2001, *Official Government Gazette* – ΦΕΚ issue Α′ 90/02-05-2001.

40 Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 6; Note that, in 2012 the CRC Committee was concerned that the NORC was not fully operational for 11 years, namely since its establishment (Ibidem supra note 20, § 11).

41 The general Greek Ombudsman was established under Law 2477/1997 (founding law), as amended and supplemented by Law 3051/2002 (ΦΕΚ 220 issue Α′), Law 3094/2003(the Greek Ombudsman for Children - ΦΕΚ 10 issue Α′), Law 3293/2004 (the Greek Ombudsman for Health and Social Solidarity) and Law 3304/2005. Its function as an independent authority was further enforced under Article 103 § 9 of the Constitution of Greece.

quasi-judicial authority has extensive investigative powers, is responsible for conducting inquiries, after receiving such complaints, as well as he has the power to give recommendations, prepare thematic reports on his own initiative and publicize matters to enhance the welfare of Roma children and youth.[42] With respect to Roma children, in a report, the Ombudsman has explicitly stressed that the Greek State has not taken the appropriate measures to ensure unimpeded access to health care for Roma children pursuant to the Constitution of Greece and Article 6 of Law 3304/2005.[43]

Both aforementioned national institutional monitoring mechanisms are generally concerned with enhancing, *inter alia*, the enjoyment of the right to health (care) of Roma children in Greece and providing guidance as to the measures the Greek State must take to ensure that its efforts for compliance with its binding obligations are appropriate for this vulnerable population group. Further, they highlight the importance of accountability and participation in the adoption of legislative measures if the Greek State is to secure the effective implementation of the obligations that flow from its recognition of every child's rights, including the right to health (care) of Roma children.

8.3.3. HEALTH-RELATED POLICIES FOR ROMA CHILDREN

The imposition on the Greek State of a legal obligation to ensure access to health care for Roma children under the right to health is only one part of the picture, given that the Greek State should comply with this obligation and translate it into the formulation of operational policies and programmes for the health and well-being of these children. Before embarking on the analysis of health-related policies for Roma children, it is essential to mention that these policies were not designed and/or implemented by the Greek State in light of the right to health framework (albeit some of these policies reflect several elements of this framework). Over the last decade, at a policy level the Greek State devoted either explicit (Roma children specific policies) or implicit attention to Roma children to create the necessary conditions of trust and confidence between Roma communities and the local health care providers. As such, the Greek State developed a number of health-related programmes that tend to enhance the health status of Roma children

[42] Articles 3 and 4, Law 3094/2003 *Official Government Gazette* – ΦΕΚ issue Α′ 10/22-01-2003; For further information concerning this institution, see, the European Network of Ombudspersons for Children at <http://www.enoc.eu>.

[43] Greek Ombudsman for Children, *Immediate Measures for the Protection of Roma Children and Social Inclusion of Roma*, Press release - 24 October 2013.

primarily in terms of Roma integration strategies rather than in light of human rights law.

In particular, as regards immunization (vaccination) of Roma children against infectious diseases, the Greek Ministry of Health has issued a number of respective Circulars. These Circulars implicitly regulate access to primary health care and to the necessary vaccinations against major childhood diseases pursuant to the National Vaccination Programme. More specifically, the Greek Ministry of Health issued two significant Circulars, namely Y1/G.P.oik 109797/08-11-2012 and Y1/G.P.oik 109805/08-11-2012, indicating specific strategies concerning access to vaccination programmes for vulnerable and at-risk children, including Roma children. Accordingly, the Y1/G.P.oik 109797/08-11-2012 Circular entitled 'vaccination programme of uninsured and without financial means children and adolescents' provides for the free vaccination coverage of children who do not have the financial means, are uninsured and reside legally or illegally in Greece. The vaccinations are conducted under the auspices of the Greek Ministry of Health pursuant to the national vaccination programme for young children and adolescents. Vaccinations are offered without any costs for parents, as the vaccines, which are not covered by the insurance organizations, come from the national stock. At the same time, early childhood immunization is also provided cost-free in Greece for certain groups of the population, including Roma children. Particularly, Y1/G.P.oik 109805/08-11-2012 Circular provides for the vaccination of infants belonging to uninsured and without financial means families against major infectious diseases.[44] Nevertheless, the vaccination among Roma children is lower than among other population groups in Greece.[45] Roma families do not adhere to the vaccination schedule that protects against diseases which can be disastrous for the health of their children and their development prospects, particular in situations where care of children cannot be provided by their families due to lack of financial means.[46] In fact, the Greek Ministry of Health has urged all hospitals in the country to raise awareness and to regularly inform Roma mothers about the potential health risks

[44] Note by way of background that the medical and vaccination coverage of children belonging to disadvantaged groups of the population has been established since 2006 under the Ministerial Decision139491/16-11-2006, *Official Government Gazette* - ΦΕΚ issue Β′ 1747/30-11-2006, on 'Determination of the requirements criteria and procedures of access to the system of hospital, medical and pharmaceutical care for uninsured and financially weak citizens'.

[45] See, European Commission, *Roma Health Report - Health status of the Roma population - Data collection in the Member States of the European Union*, EU, August 2014, pp. 43-44.

[46] Ibid.

and ensure access to vaccination programme required in preventing harm to the health of infants.[47] As such, the implementation on the part of the State of an immunization programme which is accessible to all, including Roma children and their families, implicitly indicate the State's initial response to its obligation to develop preventive health care (Part I, section 2.2.2).[48]

Nonetheless, there are problems related to the vaccination of Roma children, as a significant proportion of Roma mothers give birth unattended by a health professional (i.e., without skilled professional care). As such, Roma mothers have limited access to health information (e.g., information on vaccination programmes and schedules) and do not receive prior notification about the vaccination procedure for their non-registered children. This means that Roma mothers are less likely to have the awareness to achieve optimum health for their children and act on the basis of the best interests of their children (see Part I, section 4.2.2). Indeed, organizations, such as UNICEF, have stressed that the care a child receives, mainly the prevention of harm to the health of a child, is closely dependent on the knowledge, abilities and skills of the mother or other primary caregiver, the support the mother receives and the extent of access to care the mother has.[49]

Interestingly, since 2002 and until the end of 2013 it seems that access to health care for Roma children and their families was expressly facilitated through the establishment of 35 Centers (former Medico-Social centers) in the Roma organized permanent settlements, albeit these structures were established for a specified period (i.e. limited timeframe) by the Greek State (i.e. the Greek Ministry of Health) without providing clarification on their further viability.[50] The provided

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47 Greek Ministry of Health, Circular Y1/G. P. oik. 10980/28-11-2012 on '*Reminding of Vaccinations'*.

48 Ibidem supra note 15, Article 24 § 2 (f) CRC; See also Annex 2.

49 See, e.g., UNICEF, *Women Motherhood Early Childhood Development: Exploring the question of how poor Roma women's status and situation influences children's survival, growth and development*, Hungary: Regional Office Central and Eastern Europe & the Commonwealth of Independent States, 2011, p. 7, <http://www.unicef.org/ceecis/Women_Motherhood-07-21-2011-final-WEB.pdf>

50 Joint Ministerial Decision No. 113956/02-10-2002, *Official Government Gazette* - ΦΕΚ issue Β′, 1295/04-10-2002. Of note, this initial Decision set out the establishment, management, assessment, monitoring and implementation procedure of the then Medico-Social Centers; Joint Ministerial Decision 1.5422/oik. 31022/02-05-2011, *Official Government Gazette* - ΦΕΚ issue Β′ 824/12-05-2011 on '*System for the Management, Evaluation, Control and Procedure for the Implementation of Action -Centers for the Support of Roma and Other Vulnerable Groups- in terms of the National Strategic Framework for the Period 2007-2013*'.

activities under this infrastructure included, *inter alia*, counseling, provision of basic health care services and vaccination of children, health education, provision of support in the process for acquiring adequate housing, registration and monitoring of their needs for planning further policy actions with ultimate aim the social inclusion of this population group and the elimination of discrimination practices against this group.[51]

Additionally, for the year 2012 KEELPNO (Hellenic Center for Disease Control and Prevention) in close cooperation with respective regional authorities from the Greek Ministries of Health and of Employment carried out a programme for the protection and promotion of health as well as for the provision of psychosocial support for Roma children and their families.[52] More specifically, KEELPNO through its mobile health-care units launched visits to the Roma temporary halting sites based on its overall mandate to promote public health and in terms of the specific tasks assigned to it by the Greek Ministry of Health, namely to conduct clinical examinations and vaccinations; to provide psychosocial support and consultation; to place greater emphasis on issues concerning restrictions of infectious diseases and Roma children vaccinations; and to record living conditions at the local level.[53] It seemed that such a practice intended not only to promote access to primary health care, but also to absolve Roma children and families from their fear of stigmatization and their distrust towards public (health) services with ultimate aim their social integration.[54] This would in turn help them safeguard and enhance their health and well-being and motivate them to adopt behaviors that would limit the future spread of infectious diseases. Importantly, the provision of such elaborate activities (i.e. covering both access to health care and the determinants of health) under the Greek Ministry of Health in cooperation with the KEELPNO reflect indirectly the State's intention to create conditions to assist and enable Roma children to enjoy their right to health, in light of its 'obligation to fulfil', a State's duty flowing from the right to health (see Part I, section 3.3). Nonetheless, the drawback of such initiative is its limited duration, namely until the end of the year 2012. At the same time, it must be recognised that such a limited duration is problematic but so too is the process followed by the Greek State, namely the non-participation of the intended beneficiaries (i.e., Roma children and their families) in the design, implementation and evaluation of this programme.

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51 Ibid.; See, ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010, p. 11.

52 Greek Ministry of Health, Ministerial Decision P2a/GPoik.27578/13-03-2012.

53 Ibid., §§ 2 and 4(II).

54 Ibid., § 3.

Thereto, the point to stress is that constructive dialogue between the State and the target group rather than State directives must inform the type of measures targeted to Roma children and their families (see Part I, section 3.5).

Meanwhile, in response to the initiative of the European Commission on the development of national strategies for the integration of Roma up to 2020, the Greek State has taken action, *inter alia*, to facilitate access to primary health care for Roma children and their families. For that purpose, a special joint commission from the Ministries of Health and Labour was established aiming at introducing the measures required for the operationalisation of the national strategy in the area of health. In fact, in terms of developing relevant and targeted measures to the health needs of Roma children, the commission identified the following action-areas (as part of the Greek State's commitment to enhance the health status of this group):

- Public health - hygiene, proper nutrition and oral hygiene.
- Environmental hygiene
- Disease prevention and health promotion, involving access to primary health care
- Disease prevention and health promotion dealing with matters of mental illness and drug addictions
- Access to health care – health education.[55]

The above mentioned list of specific activities to be undertaken illustrate how the Greek State seeks to determine the nature of health needs of Roma children and make available appropriate facilities to explicitly address such needs within its jurisdiction, which largely reflect the right to health obligations under the CRC (see Part I, section 2.2.2). Areas, such as proper nutrition, hygiene, environmental sanitation and prevention against diseases, are critical to the health and development especially of younger Roma children, as attention to such areas can prevent potential health risks in the long-term (see Part I, section 4.2.2 – early childhood).[56] At the same time, the increase of low vaccination rates among Roma children constitutes a State's priority, as already mentioned. For this reason, the Greek Ministry of Health in close cooperation with other relevant actors, such as non-governmental organizations, local and regional authorities, developed a project for the education of Roma children and their parents in terms of health promotion, involving

[55] Ministry of Labour and Social Security, *National Strategy Framework for Roma*, December 2011, pp. 8 and 22.

[56] See, UN CRC Committee, General Comment No. 7: *Implementing Child Rights in Early Childhood,* UN Doc. CRC/C/GC/7/Rev.1, 1 November 2005, § 27(a)-(b).

appropriate immunization, hygiene and sanitation.[57] Uptake of this project was attributed to the need to access primary health care and health promotion for Roma children and their families, mainly because of findings that either few Roma children had received the necessary vaccination; or their parents/legal caretakers, on whose Roma children are largely dependent, had not filed the necessary medical certificates for their registration to school. This assertion indicates that this project was designed with an absence of the right to health framework. Note by way of background that all children are required to be medically checked-examined; follow the vaccination schedule; obtain a child's health booklet; and a medical certificate as prerequisites to their acceptance in primary education.[58]

At the same time, due to the development of this project the Greek State is expected to obtain record of Roma communities, vaccination records for Roma children as well as issue official documentation-identity cards, a decisive factor in access to health care for Roma families (see section 8.4.3).[59] Furthermore, in terms of the initiative entitled 'Health education- Intervention' conducted -albeit not designed in light of human rights law- under the auspices of the Greek Ministry of Health in intercultural schools, Roma children received free dental care. In general, access to dental care for this population group is rather limited and Roma children and their families in their vast majority are unaware of the basic rules of oral health-hygiene.[60]

Nonetheless, certain shortcomings in health care and especially preventive care have been identified in several cases concerning Roma children in regions of Greece. Reports focusing on certain local situations suggest that the health conditions of Roma children are far worse than those of the majority of the population. Life expectancy of Roma children in Greece is a decade lower than

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[57] Greek Ministry of Health, Y1/G. P. 95720/16-09-2011 and Y1/G. P. 130064/28-12-2011.

[58] Greek Ministry of Education, PD 200/1998, *Official Government Gazette* - ΦΕΚ issue Α′ 161/13-07-1998, 'Organization and function of nursery education' and PD 201/1998 *Official Government Gazette* - ΦΕΚ issue Α′ 161/13-07-1998, 'Organization and function of elementary schools'. A Child's health booklet is compulsorily given to parents of the infant at its discharge from the maternity hospital. Note that every school year health education interventions are implemented in schools by hospitals/health centers, medical associations and other respective bodies, which conduct preventive controls and tests, and provide information on health prevention (23rd Greek report on the European Social Charter and 8th National Report on the implementation of the Additional Protocol of 1988, XX-2 (2013), CoE).

[59] European Commission, *The European Union and Roma- Factsheet. Greece*, April 2014.

[60] Greek NGO's network for children rights convention, *Non-Governmental Organizations' Report in Application of the United Nations Convention on the Rights of the Child- Greece*, Athens, April 2011, p. 18.

that of the general infantile population.[61] Infectious diseases disproportionately affect Roma children and in recent years there has been a significant increase in the number of cases of such diseases among Roma children. For instance, since 2013 an increased number of hepatitis A -a vaccine preventable disease- was reported mostly affecting Roma children with new such cases occurring also in 2014. Reported outbreaks and clusters of such cases mainly affected camps in the regional units of Northwestern Greece and Thrace.[62] Such outbreaks can be the result of the State's failure to implement Roma children specific preventive strategy, namely the lack of well-coordinated preventive health care programs (i.e. immunization program etc.); poorly defined or stigmatizing health raising-awareness campaigns; lack of a policy that is participatory in design and implementation; and lack of community-based primary health care linked to the remote geographical location of Roma housing (see below section 8.4.2). Thus, there is a lack of a comprehensive and systematic state policy action designed in light of the right to health framework that shapes measures targeted at the particular health needs and best interests of Roma children (see Part I, section 4.2.2).

Meanwhile, in 2010 a new policy action -albeit in collaboration with the Council of Europe- was introduced in Greece, namely Roma health mediation. In particular, this policy action aims to increase access to health care for this population group and is targeted at addressing their particular health needs and the obstacles that confront their ability to enjoy their right to health and health care.[63] Roma health mediation is a joint programme under the auspices of the CoE and enables through its interventions access to culturally sensitive health care for this population group.[64] More specifically, the Greek State agreed to participate in and develop the Roma

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[61] Ibid., p. 17.

[62] K. Mellou, T. Sideroglou (Hellenic Center for Disease Control and Prevention), Increased number of hepatitis A reported cases among Roma in 2013 and January 2014, Greece, *e-bulletin - HCDCP - Ministry of Health*, 35(2014), pp. 9-10.

[63] See, Council of Europe, The Strasbourg Declaration on Roma, adopted 20 October 2010, at the Council of Europe High Level Meeting on Roma in Strasbourg, CM(2010)133 final, §§ 35, 46.

[64] Ibid. Note that in 2010, the Council of Europe began the European Training Programme for Roma Mediators – ROMED – in order to enhance the quality and effectiveness of (school/health/employment) mediators and existing training programmes, aiming at achieving better communication and co-operation between Roma and public institutions (schools, health-care providers, employment offices). ROMED leaflet, Mediation for Roma, Intercultural mediation for Roma children, a joint Council of Europe and European Commission action, Council of Europe Support Team of the Special Representative of the Secretary General for Roma Issues.

health mediation programme in the country with the aim of promoting communication between Roma communities and public institutions on significant matters, involving, *inter alia*, health care. Notably, this state action -albeit not designed in light of human rights law- is consistent with the requirement as established in Article 24 § 4 CRC, which underlines the need for the State's engagement in international co-operation as a means of ensuring the right to health (Part I, section 4.4).[65] Roma health mediators are suitably trained, with a good knowledge of Roma matters and usually members of the Roma communities who can speak the language of the Roma community they are working with.[66] They are tasked with enhancing the health status of Roma communities by mediating between the patients and the health personnel during consultations; communicating with Roma communities on behalf of the public health system; and generally by facilitating communication between Roma and health care providers. At the same time, Roma health mediators engage in alerting Roma children and families to the significance of preventive care and vaccination through facilitating vaccination and other health-related campaigns in Roma communities. As such, Roma heath mediators are involved in organizing health education sessions to Roma children and families, and providing information on issues concerning reproductive health, maternal and child health. Furthermore, Roma health mediators are concerned with the protection of patients' rights by facilitating access to judicial and other remedies for Roma to claim health entitlements.[67] From the above, it becomes obvious that such a practice aims at providing Roma children and families with assistance towards health care providers and enhancing availability of health care services, highlighting gaps in their access to health care and ultimately ensuring an unimpeded enjoyment of the right to health (care) for this vulnerable population group.[68] However, it is

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65 Ibidem supra note 15.

66 Ibidem supra notes 63 and 64. Up until 2014, in Greece there are 75 Roma mediators and 4 training programmes have been organized. <http://romed.coe-romact.org/countries/greece >

67 Ibid.; The CRC Committee has stressed in its concluding observations on Greece that many children and families coming from distinct ethnic groups, such as the Roma, are unaware of their rights to social security and welfare, and are consequently unable to claim such assistance. (UN CRC, CO: Greece, UN Doc. CRC/C/15/Add.170, 2 April 2002, § 62(d)) In this regard, the Committee has recommended Greece to strengthen the provision of information about such benefits to children and families in need of assistance, including the Roma. (§ 63(d))

68 Council of Europe, *The Council of Europe: Protecting the Rights of Roma*, Strasbourg: the Council of Europe's Directorate of Communication in collaboration with the Support Team of the Special Representative of the Secretary General for Roma Issues, September 2011, p. 19.

noteworthy that this seemingly well-intended project is still at a primary stage in Greece, namely at the training of Roma mediators, and, thereby, its effectiveness and impact on the health status of Roma children remains to be seen.

All in all, the preceding analysis, set out in sections 8.3.2 and 8.3.3, demonstrates that the Greek State has rarely considered implementing the implications of the right to health in a consistent and coherent way within the adoption of laws and policies in relation to Roma children. The point to stress therefore is that the State's legislative decisions and policy measures were not duly informed by the right to health as a guiding principle -put simply they were designed with an absence of the right to health framework- and certain alarming issues can be detected as a result. Thereto, the subsequent section further elaborates on this observation and presents a reflection on the implementation of such law and policies and their effects, primarily in terms of the concerns raised in light of the internationally guaranteed right to health.

8.3.4. REMAINING ISSUES

In light of Part I and sections 8.3.2 - 8.3.3, this section will analyze Greece's compliance with its responsibilities under the right to health (care). In this regard, the work of the CRC Committee tends to provide some guidance through its exhortations on States' reports as to the assessment of respective States' efforts (see Part I, section 4.2.2). Thus, in order to measure compliance of Greece we will also gain perhaps some knowledge from the concluding observations of the CRC Committee on respective reports of the Greek State on the status of Roma children's right to health and access to health care. As mentioned in Part I, specific right to health obligations stem from the CRC which is binding for Greece. Instead, access to healthcare and health-related policies for Roma children in Greece were not designed in light of the right to health framework, but rather sporadic state efforts were made towards this perspective (see sections 8.3.2 and 8.3.3), as also will be subsequently analysed. The Greek State is struggling with its obligations under the right to health and health care. However, progress in this field has been slow and remains below expectations. Specifically, when looking at the respective legislation and policies for Roma children developed by the Greek State from the perspective of the 'AAAQ' criteria enshrined in GC No. 14, which were analyzed in Part I of the present study (see Part I, section 3.5), some points of great concern and several inadequacies can be discerned.

Particularly, with respect to the issue of availability of health care services, the CRC Committee has repeatedly emphasized the weaknesses of the health infrastructure, the inadequacy of medical staff in the health system and the Greek

State's duty to recruit additional nurses and social workers to respond to the diverse needs of all children, especially Roma children due to their increased vulnerability (see section 8.2).[69] Instead, over the years, the Greek State has launched several fragmented health policies in relation to Roma children, without careful planning and coordination, namely without setting concrete priorities and targets to be achieved within a particular timeframe and tailored to the particular needs of this vulnerable population group (see Part I, section 4.2.2). Certainly, such State's response towards Roma children is also not in line with the State's obligation for progressive realization of the right to health (see Part I, section 3.4). Importantly, the Greek State has denied those children the right to preventive care by not providing community-based primary health care, namely in close proximity to Roma communities, involving, *inter alia*, the development of multidisciplinary information (i.e., reproductive health education) and advice (i.e., child-sensitive counselling services for Roma children and their families) about the negative impact of early pregnancies linked to early marriages on health and development; and by not systematically implementing coordinated and well-resourced immunization programs, with serious consequences for both Roma children's health and public health in the long-term, as elaborated in section 8.3.3.[70] Preventive care, by definition, should be provided before the medical condition of an individual deteriorates (i.e., reaches an emergency) and include measures, such as preventive medical check-ups, vaccinations against major infectious diseases and early detection of disease.[71]

A second point of concern is accessible health care without discrimination, one of the elements of accessibility under the 'AAAQ'.[72] In light of this principle, it requires special attention that the CRC Committee has hinted at the State's failure to remove discrimination against Roma children in its report for Greece where it noted 'the negative attitudes, prejudices and discrimination against children of minorities and in particular Roma children, especially with regard to disparities, poverty and their equal access to health' and the underlying determinants of health, such as 'birth registration, housing, and a decent standard of living'.[73] Put simply,

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[69] Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 53 and 72(b); Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 56.

[70] See, also, European Commission, *Roma Health Report - Health status of the Roma population - Data collection in the Member States of the European Union*, EU, August 2014, p. 43

[71] Ibid., p. 99. It is indicative that 32% of Roma children use emergency services in Greece; See, e.g., WHO, *Glossary of Terms*, Geneva: World Health Organization 1984, p. 17; WHO, *A Glossary of Terms for Community Health Care and Services for Older Persons*, Japan: WHO Centre for Health Development 2004, p. 47.

[72] Ibidem supra note 19, GC No. 14, § 12(b).

[73] Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 71.

Greece has failed in practice to treat this population group on the basis of medical criteria along with the diverse characteristics and needs of this group by means of integration in health care delivery. This could be a disturbing development in that in principle the Greek State has enacted Law 1397/1983 on the provision of healthcare equally to all citizens as well as Law 3304/2005 on equal treatment and non-discrimination on ethnic grounds, as mentioned earlier. Instead, Roma children, even if not overtly denied health care *via* the law in Greece, often experience lower access to health care and their health suffers additionally from their poor socio-economic status in society, which also raise human rights concerns, as will be more fully analyzed in section 8.4.

Importantly, when care is available for Roma children, it is disproportionately expensive for them and their families relative to their apparent inability to pay, due to the increasing demands on payments for health care, involving the introduction of additional increased user fees especially during the economic recession of Greece (see section 6.4.2.3).[74] Nonetheless, such developments could result in delays in seeking treatment for a health problem that could have been easily rectified owed to early diagnosis and medical follow-up, and in the inability of Roma children and their families to act on medical advice, namely to afford to pay for medication. This situation raises concern in light of the principle of economic accessibility which requires, based on the principle of equity, health care to be available and affordable to all, including socially disadvantaged groups (Part I, section 3.5).[75] The CRC Committee in its 2012 report expressed concern that 'the right to health and access to health services is not respected for all children, with regard to the fact that some health services have to be paid in cash and in advance, which may hinder the access to these services especially for Roma children,…'.[76]

Furthermore, another issue of high concern is physical (geographic) accessibility of health care for Roma children, primarily as regards to the distance and travel time to health facilities and services in connection with the absence of convenient and affordable transport (Part I, section 3.5). This essential element of 'accessibility' under the 'AAAQ' requires due attention in that Roma children and their families run the risk of not having timely access to health care owed to structural factors, such as lack of the necessary health infrastructure, namely health care personnel and facilities, in remote areas and less developed regions where they live, as was extensively analyzed in chapter 6 and further elaborated in section

[74] Ibid., UN CRC Committee, CO: Greece 2012, § 17.
[75] Ibidem supra note 19, GC No.14, §12(b).
[76] Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 52.

8.4.2.[77] Additionally, as pointed out in section 8.3.3, a limited number of prevention health programmes are carried out sporadically -within a limited timeframe- only in Roma organized settlements, which could be an alarming development in the prevention of infectious and transmittable diseases and thereto, it signal dangers for the individual and population health.

Along with the concerns raised in light of the 'AAAQ' criteria, the question arises how the notion of 'accountability', as set out in chapter 3 (see Part I, section 3.5), is given due attention for addressing possible failures to realize the right to health (care) of Roma children at the legislative and policy levels. As noted in section 8.3.2, accountability is implicitly conceptualized primarily through two institutional authorities, whose decisions, recommendations and reports are not legally binding, namely the National Observatory for the Rights of Children and the Greek Ombudsman for Children and especially its special office for Roma issues. In fact, in response to the repeated CRC criticism, the Greek Ombudsman for Children has urged the Greek State to develop a national strategy that will protect, *inter alia*, the right to health (care) of Roma children through addressing their special health needs within relevant targeted health interventions and taking into account their heightened vulnerability due to the increasing pressure exerted upon this group from the on-going economic crisis and the several austerity measures in Greece.[78] Nevertheless, it is noteworthy that the Greek Ombudsman for Children -separate investigation team for Roma- can only deal with a failure concerning the right to health (care) of Roma children after having received a claim to investigate an individual case. In this regard, attention could be given to the support and development of accountability mechanisms that enable Roma children and their families to know and claim their right to health (care), including accessing means of redress. Another cause for concern is the adequacy of the functioning of the National Observatory for the Rights of Children given that this body, based on its overall mandate, is responsible for monitoring and ensuring the implementation of the CRC in Greece. Indeed, in its 2012 report to Greece, the CRC Committee noted with concern that this body had not been fully functional since its establishment, nearly for 11 years.[79]

In addition to accountability, it is important to stress that the Greek State has not systematically integrated another core human rights principle, namely the

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[77] Ibid., § 72(c); Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 57(a); Ibidem supra note 18, UN CESCR, CO: Greece 2015, §§ 35-36(b) and (d).

[78] Greek Ombudsman, *Adoption of a National Action Plan for the Rights of the Child*, Press release-12 September 2013.

[79] Ibidem supra note 20, § 11.

principle of participation, in accordance with the best interests of this group, as was pointed out in chapters 3 and 4 (see Part I, sections 3.5, 4.2.2 and 4.2.3), into the process of formulation of its national policy and programme response for the diverse health needs of Roma children. The earlier-mentioned national policy measures (section 8.3.3) were not regulated and undertaken in consultation and collaboration with Roma children and, as appropriate, with their families that have the capacity to impact on young Roma children's health, even though required under articles 12 and 5 CRC respectively, which is binding for Greece under Law 2101/1992 and prevails over any other contrary provision of law.[80] Participation of Roma children and their families in the decision-making process could have provided the Greek State the necessary means to create conditions that will affect the effectiveness of health-related policies and programmes addressed to them.[81] This means that participation of this population group could assist in identifying its particular and discrete health needs that must be addressed, as well as the need for systemic state responses to barriers to needed care, such as discrimination or inaccessible services.

Importantly, the realization of the right to health involves, *inter alia*, the active involvement of individuals and communities by providing them with a genuine voice in the decision-making process (i.e., as to the decisions that determine and affect their health).[82] In literature it is pointedly argued that a significant purpose of participation in the context of the right to health is 'to recognize and respect difference and diversity within the population', through ensuring inclusiveness in the development of health policy (Part I, sections 3.5 and 4.2.3).[83] Nevertheless, as reflected in sections 8.3.2 and 8.3.3, the Greek State has been averse to conforming laws and policies to meet this key element of the right to health and as such, participation is not conceptualized to the legal and policy context within which Roma children are situated. The Greek State has not developed systematic institutional structures for Roma children and their families' participation in the formulation, implementation, evaluation and review of health programs, strategies and plans. Notably, the CRC Committee has repeatedly emphasized the need for participation of this group by urging the Greek State to 'continue and strengthen its efforts to develop and implement policies and programmes towards improved

[80] See, Article 28, Constitution of Greece; See, also, Chapter 5 with regard to the supremacy of international law over national law.

[81] Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 72(a).

[82] Ibidem supra note 19, GC No. 14, § 54; See section 4.2.3.

[83] H. Potts, *Participation and the Right to the Highest Attainable Standard of Health*, Essex: Human Rights Center 2008, p. 20.

respect for the rights of Roma children, including through cooperation with representatives of the Roma themselves and through empowerment of Roma communities'.[84]

While the concluding observations of the CRC Committee are not legally binding for Greece, they tend to provide some authoritative material for pointing out particular issues of great concern that Greece, in order to comply with its right to health obligations, must address. Of further importance, beyond the State's non-compliance to its right to health obligations within national law and policy context, is the apparent gap between the law and the living reality of Roma children, namely with respect to their socially constructed characteristics, namely their low socio-economic status, which also raise human rights concerns, as will be more fully analyzed subsequently (section 8.4).

On the basis of the prevailing health-related policies and programmes for Roma children (see section 8.3.3), it is indicative that the Greek State places emphasis on the vaccination of Roma children, albeit not on a systematic manner, without at the same time effectively addressing the diverse health needs of Roma children in conjunction with their socio-economic conditions. This means that the Greek State needs to adopt comprehensive context-sensitive measures, namely policies that respond to and tackle the challenges faced by Roma children, especially in relation to their characteristics and circumstances in which they live and the different developmental stages during their life course. Such measures can include the promotion of outreach primary health care due to their different lifestyle and of continuum health care, involving prenatal, natal, maternal, early childhood and adolescent health care. At the same time, it is noteworthy that the consideration of the special needs and characteristics of Roma children in terms of realizing their right to health (care) is not intended to neglect the needs of other groups of children in Greece. On the contrary, the realization of the right to health (care) for Roma children should be addressed in line with the right to health (care) of other groups of children in society in a State's effort to promote integration of these groups in law and policy-making.[85]

All in all, from a health and human rights perspective, a thin legal grounding for the right to health and access to health care for Roma children is construed in national law (i.e. lack of Roma children specific legislation), as elaborated in section 8.3.2, which may reflect the low prioritization of their diverse health needs

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[84] Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 81; Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 72(a).

[85] UN CRC Committee, General Comment No. 5: *General Measures of Implementation of the Convention on the Rights of the Child*, UN Doc CRC/GC/2003/5, 27 November 2003, § 47.

in comparison to other population groups. Added to this, the design and development of policy measures for Roma children were made in a somewhat haphazard fashion and irrespective of the right to health framework, as elaborated in section 8.3.3. Yet there are still remaining issues that the Greek State bears responsibility and is required to work on by undertaking legislative and policy measures under the right to health, targeted to the health needs of Roma children. As such, the legislative decisions and policy measures for Roma children must be sufficiently flexible to accommodate and respond simultaneously to the social, ethnic, cultural differences and diverse health 'age' needs of Roma children. In this respect, it is argued that the recognition of such difference on the part of the State constitutes an enduring concern and a requirement for ensuring access to and the enjoyment of health care of appropriate quality without discrimination.[86]

Last but not least, when it comes to health status, the high mortality rate, the low life expectancy and the high rate of diseases among Roma children in comparison to the rest of the population largely reflect the increased vulnerability of this group as well as the State's failure to effectively address this vulnerability and ensure the survival and development of those children in all different phases of their lives (see Part I, section 4.2.2). Of note, the CRC Committee expressed its concern about the poor health statistics relating to Roma children in its report to Greece.[87] Such alarming developments make clear that the concrete inclusion of the right to health within national law and policies for Roma children is totally absent and is urgently needed as a result. Although the rooted recession and economic crisis in Greece, which led, *inter alia*, in critical understaffing of the health system and in decrease in public health funding as elaborated in chapter 6, do not allow for the implementation of well-resourced programmes for Roma children, the Greek State still is required under international law to make every effort thereof and justify circumstances when those children are denied access even to low-cost health measures (i.e. measures that do not require extensive resources) targeted to their needs (see Part I, section 4.2). Unless there is a demonstrable justification, it should be seen as a denial of the right to health (care) of Roma children on the part of the Greek State. It is notable at this stage that resource scarcity should not be seen by the State as an excuse for the restriction or denial of care needed for this population group. Along similar lines, the CRC Committee has highlighted that even in times of fiscal constraints the Greek State

[86] A.C. Hendriks, 'Ethnic and Cultural Diversity: Challenges and Opportunities of Health Law', *European Journal of Health Law*, 15, 3 (2008), pp. 285-295.

[87] Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 36(b).

must give priority to the most disadvantaged groups in society, including Roma children.[88] Indeed, as observed in Part I, section 4.2, the right to health involves the state obligation to prioritize measures targeted to the needs of vulnerable population groups in society, like Roma children, during severe resource constraints.

8.4. AREAS OF CONCERN AND STEPS FORWARD

The effective enjoyment of the right to health by Roma children is influenced by several challenges that not only signal dangers of neglecting the special health needs of Roma children, but also shape access to health care for Roma children, one of the important aspects of the realization of the right to health. Particularly, in addition to the problems Roma children face in accessing health care in Greece, they also face other difficulties that impact upon their health and access to health care, and stem from the underlying determinants of health. Importantly, the realization of the right to health of Roma children is closely connected to and dependent upon the realization of other human rights, including the right to an adequate standard of living, the right to housing, the right to birth registration and identity. These human rights at a large extent constitute the underlying determinants of the health and form the general content of the right to health (see Part I and Annex 1).[89] As such, the right to health together with these rights obliges Greece to enhance Roma children's social and living conditions, which are also significant causes of their limited access to health care, as will be subsequently elaborated.

Most notably, life expectancy of Roma children in Greece is a decade lower than that of the general infantile population, as mentioned earlier.[90] WHO has pointedly stressed that the 'structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries'.[91] Thereby, three specific health-related challenges which influence Roma children's health status and are enduring concerns for the CRC Committee, in that they may constitute a threat to the objectives of the right to health of these children coupled with future steps on the part of the Greek State will be underlined below.[92]

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88 Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, §§ 6 and 18(b).

89 Ibidem supra note 19, GC No. 14, § 3.

90 Ibidem supra note 24, Greek NGO's network for children rights convention, April 2011, p. 17.

91 Ibidem supra note 9, p. 1; See, e.g., P. W. Newacheck, D. C. Hughes and J. J. Stoddard, 'Children's Access to Primary Health Care: Differences by Race, Income and Insurance Status' *Pediatrics* 1996, 97 (1), pp. 26-32.

92 The CRC Committee has repeatedly pointed out Roma children poverty, poor standard of

8.4.1. ROMA CHILDREN POVERTY

Child poverty not only encompasses income deprivation but also constitutes the underlying factor for poor health status and less development opportunities among children.[93] The level of poverty experienced by many Roma children is extreme in Greece.[94] Roma children live in disproportionately poor conditions compared to other children with negative effects on infant health and their development prospects.[95] Meanwhile, due to the interaction among environment and human development poverty's negative effect is more intense in early childhood than its impact experienced in later life.[96] Poverty of Roma children contributes to higher infant mortality rates, lower life expectancy and a higher rate of vaccine-preventable diseases, as indicated above. Put simply Roma children are exposed to numerous threats to their health and well-being during their childhood, such as hunger, malnutrition, perinatal problems and infectious diseases, which can determine health in later life and into the next generation.[97]

Such disturbing developments are further exacerbated when looking at the introduction of a number of austerity measures in the area of health since 2010 by the Greek State (see section 8.3.4 'economic accessibility'). The Greek State imposes an excessive financial burden upon Roma children and their families, and

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living-housing conditions and the low level of birth registration among Roma children in its observations for Greece. See infra notes 98, 100, 106, 119, 120 and 121; Ibidem supra note 18, UN CESCR, CO: Greece 2015, §§ 29-30 and 33-34; Note that in addition to the CRC Committee and the CESCR, several other organizations, such as the ERRC, FRA, UNICEF and WHO, have voiced their concern as to these three health-related challenges (see infra notes 94, 95, 96, 102, 103, 104 and 117).

93 WHO, *The European Health Report 2005. Public health action for healthier children and populations*, Copenhagen: WHO Regional Office for Europe, 2005, pp. IX-X, 51.

94 According to the 2014 FRA survey data, unemployment rates for Roma are three times higher compared to the non-Roma living nearby and the general population. As a consequence, the proportion of Roma children who live in households falling below the national at-risk-of-poverty line is twice (42%) as high as that of non-Roma children living nearby. Further, it is reported that Greece has the second highest child hunger rates after Romania. European Union Agency for Fundamental Rights (FRA), *Roma Survey - Data in Focus: Poverty and employment: the situation of Roma in 11 EU Member States*, Luxembourg: Publications Office of the European Union 2014, pp. 22, 37 and 41.

95 WHO, *Poverty and social exclusion in the WHO European Region: health systems respond*, Copenhagen: WHO 2010. <http://www.euro.who.int/data/assets/pdf_file/0006/115485/E94018. pdf>

96 WHO, *Early Childhood Development: a powerful equalizer*, Geneva: World Health Organization 2007; WHO, *The European Health Report 2009. Health and health systems*, Copenhagen: WHO Regional Office for Europe 2009, p. 48.

97 Ibidem supra note 93, WHO 2005, pp. 46-47 and 60.

as such, creates obstacles to the treatment of these children that could be prejudicial to their health in the long-term. Such a condition may deter Roma children and their families from seeking medical assistance, thereby endangering not only their own health, but also in the case of transmissible diseases the health of the general population. It was on this basis that in 2012 the CRC Committee expressed concern in the case of Greece where financial considerations have hampered the realization of several aspects of Roma children's right to health.[98]

Here, it is, though, important to note that there is no mandate under which any State should provide such measures free of charge, as the implementation of the right to health depends on the State's available resources (see Part I, sections 4.2.1 and 4.2.2).[99] At the same time, the Greek state, in order to comply with its binding right to health obligations, needs to ensure that Roma children are not deprived for financial reasons of their right to health (care) (see Part I, section 4.2). This implies that the Greek State must take steps in light of its available resources to reduce the financial burden and ensure that Roma children's financial condition does not preclude access to health care. In fact, the CRC Committee has generally recommended Greece to provide (financial) support (i.e. material assistance and support programmes) to Roma families with the aim of assisting in the care of Roma children who belong to families with low or no income.[100]

All in all, measures tailored to the needs of Roma children are required to close the health gap between Roma children and the general population in Greece.[101] Particularly, there is a need for targeted and sustainable health interventions that will be linked to State's actions concerning also other areas, such as living - housing conditions coupled also with the need of tackling poverty in Greece. It is notable that poverty of Roma children is often associated with other conditions which together can hinder the potential of Roma children to achieve optimum health and access health care, such as remote and poor housing conditions, lack of identity documents and birth certificates, which will be fully addressed below.

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98 Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 52; Ibidem supra note 18, as regards earlier expressions of concern, UN CRC Committee, CO: Greece 2002, § 61(b).

99 Tomaševski K. 'Indicators', in: A. Eide, C. Krause and A. Rosas (eds), *Economic, Social and Cultural Rights. A Textbook*. 2nd revised ed. Dordrecht/Boston/London: Martinus Nijhoff Publishers 2001, pp. 531-543, p. 543.

100 Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, §§ 48(c) and 49(a).

101 The WHO Commission on the Social Determinants of Health underlined that the promotion of equity means more than just equal treatment of all individuals. Services may need to be adapted or developed to respond to the needs of particular groups, especially those that experience marginalization. (See, WHO/CSDH, supra note 9).

8.4.2. STANDARD OF LIVING- HOUSING CONDITIONS

The way people live has a direct impact on whether they will seek and receive medical treatment in the event they require medical attention. Poverty coupled with other practices against Roma children and their families such as residential segregation, forced evictions often without any provision of adequate alternative housing make Roma children more vulnerable than other groups of the same socioeconomic status.[102] Roma children are born and live in households that often function in basic survival levels affecting negatively infant health and survival prospects in Greece.[103] For instance, the European Roma Rights Center (ERRC) has reported that a large proportion of Roma children and their families residing in Greece live in 52 improvised and dangerous tent encampments, while most others live in poorly constructed dwellings without access to basic services, such as electricity and running water and miles away from the closest towns, namely isolated from social and health infrastructure.[104] Likewise, the Greek Ombudsman

[102] Ibidem supra note 18, UN CESCR, CO: Greece 2004, § 22; Ibidem supra note 18, UN CESCR, CO: Greece 2015, §§ 33-34; In Greece, around 60% of the Roma surveyed, aged 16 and above, responded that they have experienced discriminatory treatment in health, housing, education and employment, due to their ethnic origin. A relatively high level compared to the levels of other EU countries, such as in Romania and Spain (European Union Agency for Fundamental Rights and UNDP, *The Situation of Roma in 11 EU Member States*, Luxembourg: European Commission Publications Office, 2012, p. 26); See, e.g., Complaint No. 49/2008. *International Center for the Legal Protection of Human Rights (INTERIGHTS) v. Greece,* 11 December 2009 (p. 4), there have been over 20 documented forced evictions of Roma families in Greece since 2004; Amnesty International, *Briefing -Human Rights on the Margins- Roma in Europe*, UK: Amnesty International- The Human Rights Action Center. Since 2006, more than 100 Romani families were forcibly evicted four times from the centre of Athens, where they were originally living.(p. 8)

[103] European Union Agency for Fundamental Rights (FRA), *Housing Conditions of Roma and Travellers in the European Union – Comparative Report*, Vienna: FRA, 2009; European Union Agency for Fundamental Rights and UNDP, *The Situation of Roma in 11 EU Member States: Survey Results at a Glance*, Luxembourg: European Commission Publications Office 2012, p. 24. In Greece, around 90% of the Roma households surveyed live in conditions at risk of poverty, namely lacking fundamental housing amenities, such as electricity, indoor toilet, indoor shower or bath and indoor kitchen. See, for instance, 13/02/2013 sanitary inspection report (in Greek) on the living-housing conditions of Roma in a region of Peloponnese.

[104] ERRC, Submission of the European Roma Rights Centre Concerning Greece for Consideration under the Universal Periodic Review by the United Nations Human Rights Council (HRC) at its 11th Session on 2-11 May 2011, p. 3; For instance, substandard housing conditions can be traced at the Roma settlements in Spata (near Athens), Aspropyrgos (near Athens) and Riganokampos (Patras) where access to social infrastructure is poor.

2008 annual report reveals that in Athens 'Roma live in tragic conditions right next to dumps, in shacks, without water and electricity, without basic hygiene, among rodents, and at the mercy of extreme weather conditions and phenomena, affected by epidemic diseases, mainly caused by the trash they are paid to collect and remove from all areas of Attica.'[105] Such developments are repeatedly noted with expressions of concern accompanied with exhortations by the CRC Committee in its CO for Greece.[106] Meanwhile, the geographical location of Roma housing (i.e., in remote or rural areas) can negatively affect access to health care for Roma children in terms of being an obstacle to access to regular health care and emergency treatment due to its geographical distance from health care facilities in connection with the limited transportation options (see sections 3.5 and 6.4.2.2).[107] As such, the aforementioned living conditions of Roma families in Greece tend to create dangerous unhealthy situations which could not only endanger the health of the Roma children, but also jeopardize the safety of the broader community in the long term.

All in all, such disturbing developments require special and systematic attention (i.e. adoption of support programmes) on the part of the Greek State within the context of complying with its 'obligation to fulfil' the right to health (Part I, section 3.3). Thereto, the Greek State in light of its available resources needs to create conditions that enable Roma children and their families to enjoy their right to health, such as making health-related services accessible to Roma children and their families by means of a regular basis outreach of good quality primary health care; and assisting Roma families to provide a safe living environment for the promotion of development and growth of their children.[108] Interestingly, the ECSR in the case of Greece has suggested that measures targeted to vulnerable groups should be funded to the maximum extent of the State's available resources; have a reasonable completion timeframe; their progress should be measurable; and consider the particularities of the situation of these groups.[109]

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105 Greek Ombudsman case No.16048/2007. The Greek Ombudsman Annual Report 2008, p. 40, available at: http://www.synigoros.gr/annual_2008_gr.htm

106 Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, §§ 58, 59, 71 and 72(b); Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, §§ 64(b) and 65(b); Such concerns and calls for action have been also reiterated and expressed by the CESCR in its 2015 report for Greece (CO: Greece, UN Doc E/C.12/GRC/CO/2, 27 October 2015, §§ 33-34).

107 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

108 Ibidem supra note 18, UN CESCR, CO: Greece 2015, §§ 33-34.

109 *ERRC v. Greece*, Complaint No. 15/2003, 8 December 2004, § 21.

Last but not least, it must be conceded that the prevailing economic crisis in Greece (i.e. five yearly economic recession) may pose a barrier to the implementation of targeted measures for Roma children. At the same time it must be also acknowledged that the development of such policy initiatives in close cooperation with regional and local authorities, where Roma children and their families live, is not always a matter of funding but rather a matter of political will.[110] Put simply, the Greek State should either increase resources required by means of co-operation and assistance (e.g. make use of regional funds) or allocate existing (scarce) ones (e.g. from military/taxation to health expenditure) (see Part I, section 4.2).[111]

8.4.3. BIRTH REGISTRATION

Another cause for concern from a right to health perspective is the weak level of birth registration among Roma children in Greece.[112] Generally speaking, birth registration in Greece is required by an individual for being accepted for social insurance policies and admitted to health care settings (see also Part I, section 4.2.2). Note by way of background that birth registration is regulated under Article 20(1) of Law 344/1976 which provides that a child must be registered by its parents (or legal guardians) within 10 days from its birth at the municipalities' registry offices. The birth registration forms should also be accompanied either by a medical certificate issued by the respective hospital or by a declaration of the childbirth signed by the applicant and two witnesses.[113] In addition, the above respective law

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[110] For instance, note that the CERD has cautioned in an effort to guide the coordination of national legislations and policies in a non-binding manner that States should counter 'local measures … placing Roma in camps outside populated areas that are isolated and without access to health care and other facilities'. UN Committee on the Elimination of Racial Discrimination (CERD), General Recommendation No. 27: *Discrimination against Roma*, August 2000, § 31.

[111] See, UN CESCR, General Comment No. 3: *The Nature of State Parties' Obligations*, UN Doc. E/1991/23, 14 December 1990, § 13.

[112] The right to birth registration is laid down in Articles 7 and 8 CRC and Article 24 ICCPR that are both binding for Greece and are incorporated by Law 2101/1992 and Law 2462/1997 respectively and take precedence over any other contrary national legislation. Notably, the right to birth registration is closely connected to the right to health in a way that birth registration is a prerequisite for access to health care and social security (see, e.g., UN CRC Committee, General Comment No. 15 on *the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art.24)*, 17 April 2013, UN Doc CRC/C/GC/15, § 29).

[113] Law 344/1976 'Regarding Registrations', *Official Government Gazette*- ΦΕΚ issue Α′ 143/11-06-1976.

provision should be read in conjunction with Article 49(1) of Law 344/1976, as amended by Article 4 of Law 4144/2013, where it is explicitly stressed that the act of birth registration can be extended 90 days or more from day of the childbirth, however, in that case a fine for late registration will be imposed by the respective authority.[114] Thereto, the act of birth registration ensures that a child enjoys the right to family ties, name and nationality, and acknowledges the existence of the person before the law.[115]

In Greece, Roma parents do not systematically register their children, especially when their children are not born at hospitals and/or when their families lack identity documents or remain unaware of the significance of such process.[116] Nevertheless, the lack of birth registration and identity documentation renders Roma children legally invisible in the respective Greek authorities and, as such, deprives them of citizenship and access to several social services and care benefits critical to their development such as health care and social protection benefits.[117] In essence, without birth registration, Roma children do not obtain a health booklet; are not entitled to health care benefits; have to pay the full cost of medicines and treatment; cannot enjoy the benefits of an early and appropriate diagnosis and treatment; and are not included in general prevention strategies, medical follow-ups and information about national vaccination programmes.

The ECtHR in its case law has been concerned with the interrelation between the absence of identity documentation and access to health care. In particular, the Court held that 'The internal passport is […] required for more crucial needs, for example, finding employment or receiving medical care.'[118] Of note, the lack of birth registration not only hampers access to medical care for Roma children, but

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114 Law 4144/2013 'Dealing with violations within social security and employment market and other provisions of the Ministry of Employment, Social Security and Welfare', *Official Government Gazette*- ΦΕΚ issue Α′ 88/18-04-2013.

115 Law 344/1976 'Regarding Registrations', *Official Government Gazette*- ΦΕΚ issue Α′ 143/11-06-1976; See also, supra note 12, Article 7 CRC. The CRC is legally binding for Greece (see Annex 2).

116 Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 32; See, also, Parliament of Greece (Period ΙΕ′ - Synod Α′), *Official Records of Parliament's Session Γ′*, Athens, 25 July 2013, pp. 47-50.

117 Legislative Decree 3370/1955, *Official Government Gazette* – ΦΕΚ issue Α′ 258/23.09.1955 as amended by Law 3284/2004 'Code of Greek Citizenship', *Official Government Gazette* – ΦΕΚ issue Α′ 217/10.11.2004; Ibidem supra note 56, UN CRC Committee, GC No. 7, § 25; UNICEF, *Birth Registration- Right From the Start*, Italy: UNICEF Innocenti Research Centre 2002; See generally, supra note 112, UN CRC Committee, GC No. 15, § 29.

118 *Smirnova v. Russia* (Application no. 46133/99 and 48183/99), ECtHR 24 July 2003, § 97.

also makes adequate data collection very difficult, as already noted. In addition, the CRC Committee repeatedly in its CO for Greece has expressed its concern about the low level of birth registration of Roma children by stressing that 'a persistent number of Roma children are still unregistered'.[119]

In light of the above, the enhancement and promotion of the birth registration process -a determinant of health- is a significant human rights concern. The Greek State may violate 'the obligation to fulfil' the right to health (see Part I, section 3.3) if it does not make sufficient efforts and/or structurally fails to create such pre-conditions for Roma children to access health care facilities, such as: to review the existing registration system and adapt the legislation to ensure free birth registration for older Roma children; to raise awareness of the importance of such process among Roma families, involving access to health care and other social benefits; and to develop sufficiently decentralized services[120], such as mobile registration units that will reach Roma children and their families living in remote and rural areas of Greece (see Part I, section 3.3). All in all, there is a need for the Greek State to make birth registration process more transparent, cultural sensitive, easy to access[121] (i.e. to understand how to participate in the formal structures) and user-friendly for Roma children and their families with ultimate aim the satisfaction of the children's pressing health needs. Here, it must be conceded that non-registration of Roma children and their resulting inability to access health care, are reflected in statistics illustrating poorer health outcomes, including higher rates of infant mortality, of vaccine-preventable diseases, such as chronic measles and tuberculosis, and a life-expectancy below the national average.[122]

8.5. CONCLUSIONS

Roma children have health-related needs, some of which are special due to their physical vulnerability, age and marginalized social status. The importance of right to health standards is that their concrete integration within the national legal and policy context has the potential to convert these needs into rights, concrete claims and State's commitments. In practice, however, such standards are largely absent from the design and implementation of national law and policies in relation to

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119 Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, §§ 71 and 32.

120 Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 40(a).

121 Ibidem supra note 20, UN CRC Committee, CO: Greece 2012, § 33 (a); Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, § 41(a).

122 See, also, Schaaf, Marta, 'Confronting a Hidden Disease: TB in Roma Communities', Open Society Institute and the World Lung Foundation, January 2007.

Roma children. It seems that the Greek State tends to avoid fully abiding by its obligations under the right to health in that it adopts implementation (legislative and policy) measures irrespective of the right to health, namely in a somewhat haphazard fashion and not by a concrete and targeted way to prevent, reduce or address threats to the health of Roma children (see Part I, sections 4.2 and Part II, section 8.3.3). The Greek State is lacking a continuous comprehensive national health strategy and a plan of action targeted to Roma children and their families. Instead, the measures taken on the part of the Greek State create several obstacles to needed care for these children that could be detrimental to their health. This is also depicted in the CRC Committee's reports to Greece where the Committee has pointedly emphasized the poor access to health care for Roma children in Greece along with a high level of health concerns regarding this group.[123]

Regardless of their legal health care entitlements Roma children and their families encounter several (informal) barriers when seeking medical assistance in Greece. While sporadic health interventions have been undertaken on the part of the State for Roma children and their families, these interventions failed to attend to their specific health needs effectively. This disturbing situation was revealed when national law and policies were evaluated against the 'AAAQ' and 'AP', essential elements underpinning the right to health. Importantly, we have pointed at several alarming developments, including excessive payments for health care and no timely access to health care for Roma children and their families from remote (socially excluded) areas, which raise issues of concern in light of the economic and physical (geographic) accessibility of health care services. Such developments cannot be considered to meet the requirement of State's responsibility to guarantee the accessibility of health facilities, goods and services, and as such they create tension with the right to health framework. All in all, the realization of the 'AAAQ' is problematic but so too is the process followed by the Greek State in the design, implementation and evaluation of health-related policies, if one considers that the State pays no attention to the promotion of participation of Roma children and their families to this end. Similarly, when it comes to the accountability mechanisms the adequacy of their functioning is questionable. Such disturbing observations demonstrate that the Greek State has not effectively and in a systematic manner addressed the implications of 'AAAQ' and 'AP' within the adoption of laws and policies in relation to Roma children (see sections 8.3.2 and 8.3.3).

At the same time, added to the aforementioned observations, in light of its available (limited at times) resources the Greek State has failed so far to adequately

[123] See, e.g., Ibidem supra note 18, UN CRC Committee, CO: Greece 2002, §§ 56(e) and 80.

address the underlying determinants of health -albeit an important aspect of the right to health (see Part I, section 3.2)- in the provisions of health care to this vulnerable group. In particular, the Greek State has not ensured that Roma children's and their parents' poor living-housing conditions do not preclude their access to health care. Additionally, the Greek State has not made birth registration process more easy to access and user-friendly for Roma families to register their children and benefit from receiving appropriate care for their children's health needs. All in all, when it comes to the overall health status among Roma children, the Greek State has failed to take into account particular vulnerabilities, dependencies and challenges, especially relating to the circumstances in which those children and their families live (i.e., the socio-economic determinants of health), which result in the weakening of their status as well as constitute significant human rights concerns. Thereto, the point to stress is that when measures for this population group are planned, the Greek State must endeavor to narrow down the gap between the law and the living reality of these children and give special consideration primarily targeted to the particular needs of this vulnerable group (see Part I, section 4.2.2).

Meanwhile, it is worth bearing in mind that the translation of State commitments into concrete actions is often impeded either by lack of resources (indicating a State's incapacity) or political will. Indeed, from a human rights perspective the distinction between a State's unwillingness and a State's incapacity is highly relevant when it comes to identify a (potential) violation of a State's treaty obligations (see Part I, section 4.2.1). Certainly, the content of the state measures as to the needs of Roma children will remain subject to resource availability and more crucially, upon the efficient use and prioritization of existing (limited) resources (see Part I, section 4.2.1) given the economic recession rooted in the country during the last five years. Nonetheless, the Greek State must ensure that any limitation of the right to health of Roma children in light of budgetary and other considerations is justified. If not justifiable and unless the Greek State has not taken measures within the scope of its powers to ameliorate the position of Roma children (e.g., to prioritize the health needs of this vulnerable group, to adopt context-sensitive measures, to promote participation in decision making etc.), its failure will implicate a lack of political will and consequently a (potential) violation of its right to health obligations towards this group (see Part I, section 4.2.1).

Last but not least, given the progressive nature of the right to health (see Part I section 3.4) and resource availability, of particular assistance constitutes the development and use of indicators and benchmarks (see Part I, section 3.6), namely a collection of disaggregated data on the number of Roma children in Greece, their

health status and specific health needs in connection with their socio-economic conditions (i.e. living conditions etc.). Such indicators are of importance in order to discern their most pressing health needs and the level of health care provided to these children (often remaining overlooked in Roma integration strategies).[124] Further, such information provides a useful tool for strengthening Greek State's accountability for violations of the right to health (care) of Roma children and promoting their participation in the process of design, implementation and assessment of relevant health-related law, policies and programs.[125]

[124] See, e.g., WHO Regional Office for Europe, *Investing in children: the European child and adolescent health strategy 2015–2020*, Copenhagen: WHO, September 2014, p. 6, §§ 24-25.

[125] Ibidem supra note 18, UN CESCR, CO: Greece 2015, § 10.

9 Conclusions and Recommendations

9.1. INTRODUCTION

The aim of the study was to adopt a practical perspective of the right to health (i.e., to move from theory to practice) by way of placing our focus on its implementation within a particular socio-economic and political context. For this purpose, the content of the right to health was assessed in light of a particular national reality by focusing on specific themes relevant to this reality. Particularly, this study focused on the national implementation of the right to health by the Greek State, whilst keeping in mind its particular challenges and realities.

The objective of the present chapter is to provide answers to the two research questions set out in the introductory chapter, chapter 1. Thereto, section 9.2 embarks on a discussion of the results in light of human rights law. Subsequently section 9.3 presents the conclusions of the study, while section 9.4 provides some recommendations in relation to the prospects for enhanced operationalisation and effective realization of the right to health in Greece.

9.2. DISCUSSION

As one moves from conception to the operationalisation of the right to health issues related to the implementation of state obligations imposed under this right arise, as found in this study. Indeed, the meaning of the right to health and its various aspects are far from settled. In fact, it was argued that this perhaps alludes that further elucidation and refinement (i.e., there is a need for an explicit and concrete textual basis) of state obligations stemming from the right to health and its various aspects is required, with attention paid, *inter alia*, to the vague and open-ended concept of progressive realization (see Part I sections 3.4 and 3.6). Nevertheless, this study illustrated that even though the right to health framework remains highly contested, it can provide some insight for the assessment of state practices. It was argued that the right to health requires States to actively assume responsibility,

namely to intervene in society for the purpose of gradually creating the conditions necessary for optimum population and individual health. In this respect, beyond access to health care attention should also be paid to the promotion of the underlying determinants of health whose influential role often remains overlooked by States perhaps due to a lack of awareness on their actual scope and impact upon people's health (see below section 9.3). Indeed, the underlying determinants of health, such as housing, adequate sanitation, have the potential to influence for better or for worse the health status of people.[1] It can thus be argued that the right to health is inextricably linked to other human rights (see Part I, sections 2.4, 3.2 and 4.3) which form its integral components and affirm the principle of indivisibility and interdependence of all human rights. Here it must be conceded that States must acknowledge the interdependence of all human rights in their laws and policies in order to achieve the full realization of the right to health and ensure better protection of population and individual health (see below section 9.3). At the same time in order to achieve such conditions it may be essential for States to regulate the behaviour of third parties (i.e., private actors) and to redress existing socio-economic health inequalities.

Meanwhile, in recognition of national realities and challenges aligned with the progressive nature of the right to health, it becomes clear that the national context will ultimately determine how and to what extent a State will guarantee the right to health within its jurisdiction. At this point, one could argue that in practice there is a risk of limited (or even a lack of) correlation between commitments and actions on the ground. Indeed, in Greece it was argued that the right to health framework tends to illuminate a path that the Greek State seems unwilling to follow in that few explicit references are made to the right to health by the legislature as well as policy measures for particular groups are taken irrespective of the right to health (see below section 9.3). As such, it was observed that the Greek State does not look at the right to health as an international norm. This is unfortunate, as it was found that the right to health framework allows for flexible interpretation and for a constructive dialogue between the State and the various stakeholders to identify particular health needs and to set concrete priorities to this end. In fact, it appears that in Greece commitments stemming from human rights and constitutional provisions fade when

[1] WHO/CSDH, *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the commission on social determinants of health*, Geneva: World Health Organization, 2008, p. 1; See, e.g., P.W. Newacheck, D.C. Hughes and J.J. Stoddard, 'Children's Access to Primary Health Care: Differences by Race, Income and Insurance Status' *Pediatrics* 1996, 97 (1), pp. 26-32.

it comes to providing access to health care to some of the most vulnerable groups in society, primarily undocumented migrants and Roma children. Indeed, one finds profound health inequalities in Greece with these vulnerable population groups either denied access or receiving substandard care.

Nonetheless, when a State is being confronted with an economic crisis this situation touches upon the question why one should not anticipate on the defense that due to lack of funds this particular State does not abide by its right to health obligations. In our analysis, we have argued that resource availability cannot be used as a defense when the realization process is failing or even more as *carte blanche* for any State (rich or poor) to do as it pleases.[2] Indeed, on account of the particular economic situation the State is required to take reasonable and deliberate targeted measures towards the progressive realization of the right to health, namely to set concrete health priorities and tangible targets as a starting point. Here it must be conceded that progressive realization of the right to health *per definition* recognizes the reality that the full realization of this right may not be feasible at once or in a short period of time. Nevertheless, it was argued that even if a State decides to lean back the level of the protection of health by way of imposing austerity measures (e.g., cuts in health care spending etc.) it is required to justify its actions/inactions in light of its available resources. At the same time it was found that the State is required to consider the pressing health needs of the most vulnerable population groups within society who require more care than others by optimally prioritizing available resources while avoiding corruption, and if necessary by seeking support from the international community (e.g., WHO).

Last but not least, we acknowledged from the examination of the Greek experience that the realization of the right to health does not depend solely on the amount of the available resources but also on the way of allocating existing (even scarce) resources within the national budget to this end without though neglecting other human rights. In fact, the view taken here is that the realization of the right to health of every individual combined with the elimination of domestic health inequalities can be achieved even in non-affluent States, like Greece, irrespective of budgetary and other considerations (e.g., legal status), if taken seriously. The next section will take a closer look at the main findings of the study and offer some reflections on the meaning and compliance with the right to health framework.

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[2] See, e.g., E. Riedel, 'The Human Right to Health: Conceptual Foundations' in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 30.

9.3. CONCLUSIONS

While States have a broad range of possible legislative, administrative and policy measures to meet their right to health obligations, it was argued that the right to health framework tends to provide insight as to the implementation process required by States to this end by regulating issues surrounding healthcare, health conditions, embedded inequalities etc. The study then identified that the components underpinning the right to health framework have the potential to inform and shape national health-related decisions and actions in terms of paying particular (priority) attention, *inter alia*, to the health needs of vulnerable and marginalised groups (e.g., Roma children, undocumented migrants etc.) at all times; to the facilitation of genuine participation of all intended beneficiaries and affected groups; to the adoption of accountability mechanisms; to the development of targeted, deliberate and concrete health policies; to the prioritization and optimization of resources, while avoiding misallocation and mismanagement of resources; to the adoption of a framework law to operationalize national health strategies; and to the collection of disaggregated data to identify health needs of discrete groups. Meanwhile, it was also submitted that given the right to health embraces also a wide range of socio-economic factors that formulate conditions in which people can lead a healthy life (GC No. 14 of the CESCR), influences such as poverty, age, ethnic and immigrant backgrounds, constitute a significant part of the realization process of the right to health. Such influences raise additional human rights concerns that States often tend to overlook them when seeking to secure health needs (e.g., see section 8.5). Last but not least, at the same time, it should be kept in mind that the process required by States remains subject to the progressive nature of the right to health and to the available resources, which highly determine the potential of the right to health framework in terms of its practical applicability in shaping health-related policy efforts and interventions.

Additionally, Part I has illustrated that there is no 'one size fits all' action plan required of States for realizing the right to health within their jurisdictions. It was found that the state obligations stemming from the right to health largely depend on national contexts (i.e., economic situation, level of development, vulnerable groups) and have to be precisely elucidated on the basis of those discrete contexts. Admittedly, the main burden falls on each State to adopt context-sensitive measures for the discrete situations and groups within its jurisdiction in line with the existing domestic conditions. However, it was observed that this development is not unlimited in that the right to health framework sets out a principal process that a State needs to follow for identifying the precise measures required, as already mentioned (see preceding observation). Overall, it was conceded that the absence

of a State's justification for the adoption of a legislation or policy that constitutes a step back in the level of protection of the right to health (i.e., adoption of retrogressive measures) can be construed as a State's non-compliance with its right to health obligations. Thereof, it can be argued that such a lack of justification dissociates a State's unwillingness to comply with its right to health obligations from a State's incapacity to do so.

Meanwhile, in Part II it was observed that Greece beyond being party to all of the primary treaties recognizing a right to health has a constitutional entrenchment of health both as a right and as a State's duty. Nevertheless, it was discussed that contrary to the human rights provisions (see chapter 2), the constitutional right to health provision (i.e., Article 21 § 3) solely establishes a general and open-ended state obligation without making any reference to specific state undertakings. In fact, it was argued that the constitutional referral to the term *citizens* in relation to the State's duty to provide health care in Article 21 § 3 generally creates a tension with the human rights framework. Indeed, it can be observed that this way of perceiving state responsibility for the health of individuals raises questions with regard to the extent of the Greek State's obligations in relation to discrete (vulnerable) population groups in society who do not possess *citizenship.* Here, the counterargument to this standpoint is that such guarantees, albeit not providing a detailed enumeration of state measures and entitlements, tend to provide more latitude for legislative and/or judicial interpretation. However, few explicit references to the right to health are to be found in case law, while at the same time there is case law with explicit references to health-related rights, namely rights being interpreted by courts to protect health (see sections 4.3 & 5.3). As such, health-related rights tend to offer more protection than the right to health itself to population and individual health. Nonetheless, on account of the content of two constitutional articles quoted in chapter 5 (see Articles 5 § 5 & 21 § 3 of the Constitution), there are elements which can be interpreted in subsidiary legislation and policy practices and ascribe a certain responsibility to the Greek State to respect, protect and fulfill the right to health. All in all, we come to the conclusion that the attachment of growing significance to the role of international law within domestic legal order as well as the constitutional recognition are significant affirmations of State obligations to foster an environment in which individuals can achieve their highest attainable standard of health.

But as inspiring and promising as the international and constitutional commitments can be, it was argued that the Greek State has failed to integrate explicitly and consistently the right to health into its health law and policymaking (see Part II, section 6.5). The (austerity) measures in the area of health generated from 2010 onwards as the State's response to the economic crisis were not formulated

and implemented within the parameters of the State's right to health obligations (see Part I, section 4.2). Here it is essential to note that this situation is partly the result of pre-existing conditions and practices (i.e., the lack of prioritization and optimization of available resources before crisis, the lack of effective accountability mechanisms against persistent corruption – see sections 6.4 & 6.5) exacerbated though by the 5-yearly economic crisis, resource scarcity and hardly manageable rising health care costs. In fact, such pre-existing practices highly demonstrate that the Greek State, besides its incapacity owed primarily to the 5-yearly economic crisis, was also unwilling to take the required measures (i.e., to set concrete priorities) under its right to health obligations even before it was hit by this crisis.

At the same time, it was also found that the introduction of austerity measures placed an increasing pressure on the functioning of the health care system. First, it was observed that the measures taken were not time bound, as their implementation indicates a permanent solution to the fight against the rising health care costs. In fact, this becomes evident when looking at the health status and health indicators in the country from 2010 onwards, namely the rising infant mortality rate and the increasing health disparities based on income. At this point, it was argued that the worrying health trends in Greece can be also related to the worsening socio-economic determinants of health which raise additional human rights concerns and are also of decisive importance for realizing the right to health, as observed earlier. These possible causes for ill-health are also avenues for future research.

So far the Greek State has also failed to demonstrate that it sought all other feasible alternatives or less restrictive measures to respond to the rising health care costs and fiscal pressures. Clearly, the Greek State has failed to involve the genuine participation of affected groups or individuals by way of establishment of participatory mechanisms easy to access, in terms of assessing their views and preferences towards the proposed (austerity) measures. The Greek State has not undertaken right to health impact assessments for the formulation and evaluation of such measures in light of the 'AAAQ' requirements and especially as regards to vulnerable population groups in society. In fact, it was argued that from the perspective of the 'AAAQ' these measures disproportionately impact on vulnerable population groups that require additional health care, such as chronically ill, elderly, pregnant women, children (e.g., with ethnic or immigrant backgrounds), undocumented migrants and drug users. Note also that in the Greek health system there is no statement of minimum level of health care, namely a package of minimum health care services to be provided under all circumstances. Thereto, when considering these alarming developments owed to the (austerity) measures introduced in the health sector especially from 2010 onwards as well as the way

of their formulation (i.e. not being reasonably justified), it can be concluded that such developments do not reflect a progression, but rather constitute a significant and evitable cause for retrogression in the enjoyment of the right to health (care) of every individual in Greece. The position taken here is that unless within the scope of its powers (i.e., its capacity) the Greek State actively intervenes to ameliorate this situation and redress the rising health inequalities (e.g., to set priorities within its health system and to allocate its limited resources to those most in need), this will certainly amount to a violation of the right to health (care).

At the same time, it was identified that Greece's economic recession and fiscal pressures as a result of its MoU associated with the growing health care costs are immensely pushing a privatization agenda. Nonetheless as emerged from the analysis (see section 6.5.1), the Greek State does not provide adequate safeguards for holding them to account for possible failures to realize the right to health, which leads to less accountability and threatens the objectives of the right to health (care). As such, due to the lack of concrete obligations for private actors combined with the lack of an articulated right to health (care) within national legal order, it is questionable whether the Greek State actually wants to abide by its right to health obligations. Admittedly, such an argument can be advocated if one considers that the national health system is rife with corruption which adds another layer of serious challenge to the realization of the right to health (care) of individuals. Indeed, in the author's view such development implicates an unjustifiable limitation of this right on the part of the State and ultimately a violation of this right.

Meanwhile, when looking at two particular population groups, namely undocumented migrants and Roma children in relation to the extent of realization of their right to health (care) in Greece (see chapters 7 and 8), we come to the conclusion that different levels of such realization exist compared to the general population within the country. Explicit references to the right to health of these groups are not made by the legislature. The challenge of mainstreaming the right to health across all health-related legislative and policy measures by paying particular attention to undocumented migrants and Roma children was discerned. It was argued that the Greek State has not integrated in a coherent and consistent manner the right to health across its national processes for these two population groups who require targeted care to their discrete needs due to their particular vulnerable position in Greece. Indeed, this alarming situation has been repeatedly criticized at the international level (see sections 7.3.6 and 8.3.4) without though resulting in these groups' right to health (care) being subject to any evaluation by the Greek State. In fact, the Greek State has not engaged in genuine and effective consultation with these population groups and/or their representatives to assess

their views as to what measures the State must undertake to secure the effective realization of their right to health. At the same time, it was discussed that the Greek State has not established effective and accessible (i.e., without fear of sanctions and/or easy to understand its formal structures) accountability mechanisms to regulate and monitor (State and non-State) actions in the health sector towards undocumented migrants and Roma children. Nonetheless, without such mechanisms the Greek State cannot be compelled to explain whether (or not) it is moving as expeditiously and effectively as possible towards the realization of its right to health duties for these groups. As a result, when looking at the overall performance of the Greek State towards undocumented migrants and Roma children, we can conclude that this is incompatible with the right to health framework. Admittedly, this situation signals dangers for individual and population health and should not remain unaddressed by the Greek State, in that it renders these population groups more vulnerable to increased health risks and a threat for others.

At the same time, the analysis carried out in both chapters revealed that in addition to the problems these two groups face in accessing health care in Greece, they also face other difficulties that impact upon their health and access to health care, and stem from the underlying determinants of health. Such developments lead to the overall conclusion that the right to health together with the corresponding rights obliges Greece to enhance the social conditions (i.e. living and housing conditions etc.) of both groups, which are significant causes of negative health outcomes. Indeed, when looking at the health status and health indicators in relation to these groups, it was found that there is a distinct lack of correlation between these two vulnerable population groups and the average person in Greece. The point to stress therefore is that such a disturbing situation reflects a non-progression of their right to health as well as reveals how social conditions largely shape health outcomes and are responsible for a major part of health inequalities within Greece.[3] Even so, it was argued that national health policies appear to be reduced to a certain number of healthcare issues (e.g. emergency treatment, sporadic immunization programmes etc.) without any relative reference to the several surrounding (socio-economic) aspects (e.g. poverty, detention conditions etc.) which constitute the overall context within which the right to health for these groups is to be implemented. Thereto in the author's view, this situation, if not justifiable, constitutes not only a clear limitation, but also a violation of the right to health of these groups.

All in all, the economic situation in Greece (i.e., resource scarcity) should not serve as a pretext for a restriction or denial of the right to health (care) for all and

[3] Ibidem supra note 1.

especially for the most vulnerable population groups. Reaching beyond the rhetoric, given the hard economic situation, in practice the Greek State has to systematically seek and implement targeted health measures that do not require extensive resources and are commensurate with its right to health obligations as well as to seek international (technical and financial) co-operation for expanding its existing capacity. When looking at the current alarming developments in Greece, one perceives a significant step back and a (potential unjustifiable) limitation in the progressive realization of the right to health (care) which is of major concern and requires more considered attention on the part of the State to challenge its key elements. In this respect, it was observed that several human rights bodies, including the CESCR and the CRC Committee, have repeatedly voiced their concerns about the rudimentary level of the integration of the right to health (care) in national legislative and policy measures. To this end no easy solutions are available that will be achieved at once and a level of legislative and administrative reform beforehand is required, as will be subsequently elaborated.

9.4. RECOMMENDATIONS

From the perspective of the preceding analysis, it can be observed that a large gap exists between national recognition of the right to health and reality (i.e. in practice). Such an observation, though, raises a critical question for exploration as well as a primary concern: what should be done on the part of the Greek State to remedy this situation? Given the gravity of domestic health concerns and the unjustifiable variance of a highly fragmented national legal framework, there is a growing need for coherence in the field of health legislation to systematically address the health inequalities and other pressing health problems that largely exist in Greece today. In order for the right to health to be effective for individuals within the Greek State, national legislation must reflect the right in such a way as to make it applicable. Hence, in addition to the two constitutional provisions and the incorporation of international treaties that set out the right to health in broad terms, a framework law (deriving from the GC No. 14 to the ICESCR) can elaborate further on this right and thus make it operational in practice (see Part I, section 4.2.1).[4] Indeed, a framework law can codify and firmly integrate international legal standards underpinning the right to health and required for its realization in national legal order and policy.[5] Thereto, the Greek State should consider adopting such a

[4] UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E./C.12/2000/4, 11 August 2000, §§ 53-56.

[5] Ibid.; See also infra note 6.

law which would be more specific than the existing national legal framework to operationalize the right to health for every individual within its jurisdiction in a coherent and consistent way.[6] At the same time the right to health can be promoted and integrated within all national health-related legislative and policy measures, including the ones addressed to vulnerable population groups (e.g., undocumented migrants, Roma children). Meanwhile, we should keep in mind that this framework law should be accompanied with appropriate mechanisms to monitor the effective implementation of the obligations that stem from its recognition of the right to health (see below).[7]

In essence, the task of this framework law will be to identify the principal commitments to the right to health for the Greek State and a regulatory system (i.e., a system of governance) for shaping and monitoring the State's primary right to health duties and subsequently the (potential) duties of non-State actors in the field of health, sensitive to national circumstances, such as rising public deficit, health inequalities and health sector corruption (see section 3.7.1 and chapter 6).[8] To this aim, four action areas (objectives), stemming from and qualified by the right to health framework, should be determined within the framework law.[9] In fact, these four action areas could provide the basis for a subsidiary legislation / ministerial decisions and/or for the review of existing legislation / ministerial decisions. Note by way of background that the formulation of these areas is primarily based on both the ICESCR and the CRC as well as is derived and specified (to some extent) from UN Guidelines and GCs (primarily GC No. 14 of the CESCR). As such, the Greek State (as party primarily to both the ICESCR and the CRC) should, in its efforts to progressively realize the right to health, embed the following areas in the framework law:

A. In keeping with the state obligations to respect, protect and fulfil the right to health (see Part I, section 3.3 - GC No. 14 to the ICESCR), the implementation of a continuous, up-to-date and comprehensive national health strategy, i.e., responsive to population health needs and (cultural) differences (e.g. ethnic

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6 Note that this practice (i.e., the adoption of a framework law) is provided in the Constitution of Greece under Article 43 § 4 which stresses that '… these statutes shall set out the general principles and directives of the regulation to be followed…'. In fact, Greece has adopted a framework law on education in 1982 which establishes institutional arrangements for the provision of higher education in the country (Law 1268/1982, *Official Government Gazette* - ΦΕΚ issue Α′ 87/16-07-1982).

7 Ibidem supra note 4, UN CESCR, GC No. 14, § 56.

8 Ibidem supra note 4, UN CESCR, GC No. 14 §§ 55-56.

9 Ibidem supra note 4, UN CESCR, GC No. 14 §§ 53-56.

minorities); including a detailed plan for the development of the health system; and ensuring the progressive realization of the right, should:

- Focus on access to health care, but also on the determinants of health, in virtue of the inclusive nature of the right to health (see Part I, section 3.2). This implies that influences on health, involving housing and living environments, inadequate birth registration and, more generally, socio-economic inequalities in society should be addressed by the Greek State (e.g., by means of subsidiary legislation due to the wide scope of health determinants).
- Embody the 'AAAQ' framework (see Part I, section 3.5), while paying due attention to vulnerable groups in society (e.g., undocumented migrants, Roma children).
- Focus the attention on marginalised and vulnerable population groups who suffer most from health inequalities (see Part I, section 4.2). For instance, ensure that these groups are not disproportionately burdened and affected beyond their means by austerity measures taken in times of resource constraints owed to circumstances, such as an economic crisis or recession.
- Ensure effective participation of all intended beneficiaries (e.g., marginalised and vulnerable groups) in the policy development process through the identification of their most pressing health needs and concerns for the purpose of influencing health decision-making (see Part I, sections 3.5 & 4.2.3). This can be achieved through regular consultations and research with all intended beneficiaries. For example, the Greek State should seek and ensure active contribution of undocumented migrants in the identification and prioritization of key elements of their right to health by creating an environment in which this vulnerable group, because of their lack of legal status, can be involved without fear of sanctions and deportation
- Recognize a minimum core of the right to health and as such provide the following essential health-related services at all times (i.e., in times of resource scarcity) as a starting point (see Part I, section 3.4):
  - Immunization programmes against major infectious diseases;
  - Early identification and intervention in epidemic and endemic diseases;
  - Basic shelter, sanitation, supply of essential food and potable water;
  - Essential medicines;
  - Reproductive, maternal (pre-natal and post-natal care, emergency obstetric care) and child health care;
  - Education and information on pressing health problems in the community;

  - Appropriate training for medical professionals (e.g., education on health and human rights).
- Identify all responsible actors (State and non-State) and ensure their active involvement, collaboration, wherever needed, and effective regulation by delineating firmly their responsibilities, on the basis of the tripartite typology of obligations (i.e. to 'respect', to 'protect' and to 'fulfil'). For example, as regards non-State actors, on the basis of the 'obligation to protect' health under the right to health, establish legal norms for pharmaceutical corporations so as to ensure an unimpeded (affordable) access to essential medicines for every individual, especially for those with chronic diseases (see Part I, sections 3.3 & 3.7.1).
- Provide access to effective (judicial or other) remedies to right to health violations (i.e. restitution, compensation, guarantees of non-repetition and amendment of legislation, rehabilitation) (see Part I, section 4.3).
- Develop a system for the collection and provision of adequate and reliable statistical and/or other disaggregated data on health indicators to measure achievement and also within the context of seriously considering (the Greek State) its reporting obligations. For instance, such data should identify the discrete (pressing) health needs of the population aligned with its characteristics (e.g., age, gender etc.) and the capacity of health-related services in both the public and private health sector (see Part I, section 3.6).
- Promote right to health impact assessments prior the adoption and implementation of proposed health programmes and interventions to identify potential negative or positive consequences for the population (i.e. as regards their needs, access to health care, financial burden) (see Part I, section 4.2.3). For instance, if the proposed intervention involves the introduction of user fees per prescription it is essential for the Greek State to undertake an impact assessment for evaluating the consequences of such intervention, primarily its financial burden for the population, especially for vulnerable groups, including those living in poverty, those with chronic diseases, etc.

Importantly, the formulation and implementation of such a comprehensive national health strategy (primarily derived from GC No. 14 to the ICESCR) by the Greek State constitutes the means to the development of an effective health infrastructure that is accessible and responsive to all, namely meets the health needs of diverse population groups.

B. On the basis of primarily Articles 2 § 1 ICESCR and 4 CRC as well as GCs No. 3 and No. 14 of the CESCR Greece should establish a detailed national

health resource framework aligned with the national strategy for health to meet population needs. This requires the delineation of clear (financing) responsibilities on this matter involving a robust framework that should:

- Ensure adequate and sustainable funding for health.
- Generate increased resources for health (e.g., economic, human), which requires raising additional national resources by means of (budget) prioritization (e.g., prioritize health funding alongside other core funding commitments, such as education and social security) as well as international resources by means of international co-operation in light of Articles 2 § 1 ICESCR and 24 § 4 CRC (see Part I, sections 4.2 & 4.4).
- Ensure equitable distribution of health funds, namely ensure needed resources for health needs of marginalised and vulnerable groups with an emphasis on community-centered primary health care and adequate referral system (see Part I, section 4.2).
- Promote evaluation and assure greater financial accountability for the use of (public) funds (see Part I, sections 3.5 & 4.2). Importantly, health funding should be clearly defined, responsive to population needs and priorities (i.e. specifying what budget is allocated for the realization of the right to health of discrete population groups), and should utilize domestic knowledge, culture and other capacities.

Such a framework would ensure that resources devoted to health are not squandered due to corruption, misallocation and mismanagement and, overall weak financial regulation and enforcement. As such, the Greek State will focus not only on the way of increasing its resources, but also on the way of allocating existing (limited) resources in the national budget (i.e. transparently, efficiently and effectively). For example, in times of a financial crisis, the Greek State cannot absolve itself from its ultimate responsibility for realizing the right to health and introduce retrogressive measures (e.g. drastic cuts in health spending) by using scarce resources as an excuse, without first exploring every possible way to raise and increase the resources required (i.e. adopting a process for optimally prioritizing budgetary allocation, imposing taxes on alcoholic beverages, tobacco and unhealthy foods etc.) (see Part I, section 4.2.3).

C. On the basis of Article 2 § 1 ICESCR and GC No. 14 to the ICESCR, Greece should establish effective, transparent and accessible accountability mechanisms to both the public and private health sector in order to ensure that all responsible actors discharge their duties (see Part I, section 3.7.1 & Part II, section 6.5.1). Such mechanisms should also involve better coordination between responsible

actors and rigorous monitoring in relation to measures adopted for securing the right to health (see Part I, section 3.5).

D. In light of Article 2 § 1 ICESCR and GC No. 14 to the ICESCR Greece should establish a fully functional independent national review (advisory-coordinating) - monitoring body (see Part I, section 4.2.1). This body should be comprised of key national institutions (e.g., the National Observatory on the Rights of Children, the Greek Ombudsman etc.) and representatives of vulnerable groups, working in close co-operation with international organizations (e.g., the WHO, other (UN) agencies etc.). Its mandate should involve seeking assistance; sharing knowledge and experiences on best-practices; and finding solutions; identifying the necessary steps to be taken on pressing national and/or transnational health issues. At the same time, such a body would provide assistance: i) in the formulation of subsequent protocols, regulations or subsidiary legislation to regulate health-specific issues, and ii) in the revision of existing legislation in the field of health inconsistent with the right to health; oversee the implementation thereof; and address at once any unintended consequences.

Last but not least, it is important to stress that the scope of the framework law on the right to health should be elucidated by the legislature, through obtaining a concrete central objective (e.g., that of designing a health infrastructure to safeguard the health of the population, that of combating and/or eliminating health inequalities), so as not to constitute a symbolic recognition of the right to health (see Part I, section 4.2.1).[10] On the contrary, in light of GC No. 14 to the ICESCR this framework law should become a living national instrument, resulting in the identification of tangible commitments to be progressively implemented by all responsible actors (i.e., State -the primary duty bearer- and non-State actors); sensitive to national circumstances; and employed by individuals or (vulnerable) population groups as a means for redress once their right to health is violated.[11]

[10] Ibidem supra note 4, UN CESCR, GC No. 14 §§ 53-56.

[11] Ibid.

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Annex 1

Typology of Rights related to Health[1]

Right to	*Relevant Provisions in HRL*	*Issues related to health*
Life	Art.: 3 UDHR, 6 ICCPR, 6 CRC, 9 MWC,10 CRPD, 2 ECHR, 2 CFREU, 4 AfCHR, 4 ACHR	Protection of the life of every person, including patients' lives; application of life saving medical treatment; investigate the causes of death
Privacy and Family Life	Art.: 12 UDHR, 17 ICCPR, 10 ICESCR, 16 & 40 CRC, 16 CEDAW, 22 CRPD, 14 MWC, 8 ECHR, 7 & 8 CFREU, 7, 10 Biomedicine Convention, 4 & 20 AfCHR, 11 ACHR	Respect of patients' rights: protection of personal information, breaches of confidentiality in the provision of health services, self-determination in terms of medical decisions, compliance or non-compliance with the principle of informed consent
Birth registration and Identity	Art.: 24(2) ICCPR, 2(1), 12 ICESCR, 7 and 8 CRC	Access to medical treatment
Prohibition of Torture	Art.: 5 UDHR, 7 ICCPR, CAT, 16 CRPD, 3 ECHR, 4 CFREU, 5 AfCHR, 5 (2) ACHR	Access to medical treatment for prisoners and other detained persons; Restrain patients with mental disabilities; Prohibition of abusive treatment: physical/mental abuse
Marry and found a Family	Art.: 16 UDHR, 23 ICCPR, 5(d)(iv) ICERD, 16 CEDAW, 8 &9 CRC, 12 ECHR, 9 CFREU, 18 AfCHR, 17 ACHR, 15 AP to the ACHR	Family planning issues, non-consensual sterilization/ abortion
Human Dignity	Art.: 1 UDHR, 10 ICCPR, 3 CRPD, 1 CFREU, 1 Biomedicine Convention, 5AfCHR, 11(1) ACHR	Core of human rights law - Central to medical treatment, medical experimentation

[1] UN CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, 11 August 2000, UN Doc. E/C.12/2000/4, § 3; See, e.g., R.J. Cook & M.F. Fathalla 'Advancing Reproductive Rights Beyond Cairo and Beijing' *International Family Planning Perspectives* Sep., 1996, 22, no. 3, pp. 115-121, p. 116; B. Toebes, 'The Right to Health and Other Health-Related Rights' in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/ Portland: Intersentia 2012, pp. 83-110, p. 83.

Right to	*Relevant Provisions in HRL*	*Issues related to health*
Access to an Effective Remedy	Art.: 8 UDHR, 13 CRPD, 13 ECHR, 7 AfCHR, 25ACHR	Accountability for professional misconduct in the health care sector, Adequate reparation: restitution, compensation, satisfaction/ guarantees of non-repetition
Freedom from Discrimination/ Non-Discrimination	Art.: 1,2 & 6 UDHR, 3 & 2(2) ICCPR, 2 ICESCR, ICERD, 2 CRC, 1-5 CEDAW, 5 CRPD, 11 & 14 Biomedicine Convention, 14 ECHR, 20-26 CFREU, 3 RESC, 2, 3, 18 (3) & (4), 28 AfCHR, 1 & 24 ACHR, 3 AP to the ACHR	Fundamental principle of human rights law, Attention to vulnerable groups in terms of access to health care and other health-related services
Participation	19 UDHR, 19 & 25 ICCPR, 12, 13 & 17 CRC, 13 MWC, 21, 29 & 30 CRPD, 8& 10 ECHR, 5-9 Biomedicine Convention, 11 CFREU, 10 AfCHR	Active involvement of individuals in decision making process, namely in decisions defining, determining and affecting their health
Freedom of Expression-Information (receive/impart information)	Art.: 19 UDHR, 19 ICCPR, 13 &17 CRC, 13 MWC, 21,29 & 30 CRPD, 8 &10 ECHR, 11 CFREU, 9 AfCHR, 13 ACHR	Access to information in the context of health, such as health risks, reproductive health, Access to personal data
Liberty and Security	Art.: 1 &3 UDHR, 9 ICCPR, 5 (b) ICERD, 37 (b)- (d) CRC, 12,14 &17 CRPD, 5 ECHR, 3 & 6 CFREU, 1 & 7 Biomedicine Convention, 6 AfCHR, 7 ACHR	Integrity, Consent to treatment, Lawful detention of (mental health) patients in case of public health hazards
Health	Art.: 12 ICESCR, 12 CEDAW, 24 CRC, 5 ICERD, 28,43 & 45 MWC, 9,25 & 26 CRPD 11 &13 RESC, 3 Biomedicine Convention, 35 CFREU, 16 AfCHR, 26 ACHR, 10 AP to the ACHR Access to health care	services and goods, to health-related rehabilitation services, to services in the area of reproductive and child health, to healthy occupational conditions, to public health programmes

Right to	*Relevant Provisions in HRL*	*Issues related to health*
Enjoy the Benefits of Scientific Progress and its Applications	Art.: 27(2) UDHR, 15(2)(b) & (3) ICESCR, 22 AfCHR, 26 ACHR	Promotion of science and scientific research in the field of medicine , *inter alia,* antiretroviral therapies and other forms of HIV/AIDS care, development of vaccines for limiting outbreaks of infectious diseases
Housing	Art.: 11 ICESCR, 21 & 27(3) CRC, 19 CRPD, 8 ECHR, 31 RESC	Precondition for the advancement of people's health-Social determinant of health, safe and adequate housing
Education	Art.: 13(1) &14 ICESCR, 24, 28 & 29 CRC, 10 CEDAW, 24 CRPD, 30, 43 & 45 MWC, 14 CFREU, 17 AfCHR, 26 ACHR, 13 AP to the ACHR	Social determinant of health, Access to education on health-related information, such as reproductive health
Food	Art.: 11 ICESCR, 27(3) CRC, 12 CEDAW, 11 RESC, 12 AP to the ACHR	Precondition for the advancement of people's health-Social determinant of health, Access to adequate and quality-nutritious foods
Social Security	Art.: 9 ICESCR, 13 & 14 CEDAW, 26 CRC, 5 ICERD, 27 MWC, 12,14,16 & 23 RESC, 9 AP to the ACHR	Social determinant of health, provision of services-benefits for the advancement of people's health
Work (employment)	Art: 6 & 7 ICESCR, 11 CEDAW, 17 & 18 CRC, 27 CRPD, 38-71 MWC, 15 CFREU, 1-4, 7-10, 18-22 & 24-29 RESC, 15 AfCHR, 6 & 7 AP to the ACHR	Social determinant of health, protection against occupational diseases, Obligation to ensure health and safety at work
Adequate Standard of Living	Art.: 25 UDHR, 11 ICESCR, 27 CRC, 28 CRPD, 30 RESC, 24 AfCHR	Social determinant of health, Adequate living conditions: access to adequate food, housing, clothing, work

Annex 2

Ratification by Greece of Human Rights Documents Recognizing the Right to Health

Treaty recognizing the Right to Health	***Ratification/ Accession/ Signature Date***	***Greek Law incorporating the Treaty***
UN International Covenant on Economic, Social, and Cultural Rights (ICESCR)	16 May 1985 (accession)	Law 1532/1985, *Official Government Gazette* - ΦΕΚ issue A′ 45/19-03-1985
UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	7 June 1983 (signature: 2 March 1982)	Law 1342/1983, *Official Government Gazette* - ΦΕΚ issue A′ 39/01-04-1983
UN Convention on the Rights of the Child (CRC)	11 May 1993 (signature: 26 January 1990)	Law 2101/1992, *Official Government Gazette* - ΦΕΚ issue A′ 192/02-12-1992
UN International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	18 June 1970 (signature: 7 March 1966)	Legislative Decree 494/1970, *Official Government Gazette* - ΦΕΚ issue A′ 77/03-04-1970
UN Convention on the Rights of Persons with Disabilities (CRPD)	31 May 2012 (signature: 26 January 1990)	Law 4074/2012, *Official Government Gazette* - ΦΕΚ issue A′ 88/11-04-2012
European Social Charter (ESC)	6 June 1984 (signature: 18 October 1961)	Law 1426/1984, *Official Government Gazette* - ΦΕΚ issue A′ 32/21-03-1984
Revised European Social Charter (RESC)	18 March 2016 (signature: 3 May 1996)	Law 4359/2016, *Official Government Gazette* - ΦΕΚ issue A′ 5/20-01-2016
Biomedicine Convention	6 October 1998 (signature: 4 April 1997)	Law 2619/1998, *Official Government Gazette* - ΦΕΚ issue A′ 132/19-06-1998

Summary

Seven decades since its recognition in the preamble to the Constitution of the World Health Organization (1946), the right to health has increasingly attained a prominent position in human rights law. As a result, this right has the capacity to influence the health and well-being of all individuals worldwide. Despite the absence of worldwide consensus as to its meaning and various aspects, this thesis seeks to move from its conception and recognition to its realization, namely beyond the international formulation of the right to health. This requires a better understanding of the State measures required with the aim of bringing the right to health closer to national realities and in the daily lives of individuals. With this foundation as a basis, this study aims to examine the national implementation of the right to health and particularly the Greek context as it relates to the right to health. For this reason, this study has been built upon two interconnected parts (Part I and Part II) that each deals with one research question. Accordingly, the following two main questions are analyzed:

(a) What primary standards derive from the right to health on the basis of human rights law?
(b) Is the right to health being (effectively) implemented in Greece (or not)?

Part I contains 3 substantive chapters (i.e. chapter 2, 3 and 4) that target to frame the right to health, primarily by identifying the normative content of the right to *highest attainable standard of health* in human rights law as well as its implications for a State in terms of its operationalisation within a State's jurisdiction. More specifically, chapter 2 presents an account of the development of the articulation of the right to health as it appears in international, regional and national contexts.

Chapter 3 closely looks into the nature and scope of the right to health, the State obligations arising from it as well as two concepts which signal dangers for

its realization (i.e. privatization and corruption) primarily within healthcare settings. The purpose of this chapter is to provide an understanding of the various aspects of the content of the right to health, namely to turn the broad and abstract notion of '*the highest attainable standard of health'* into concrete concepts that can be utilized for its effective realization worldwide and especially when it comes to implementing this right at the national level. It is this particular aspect of the right to health that constitutes the basis of the discussion in chapter 4.

Chapter 4 focuses on the meaning of realizing the right to health on the part of the State by examining the extent of contribution of respective monitoring bodies. The purpose of this chapter is to define the type of measures and policies that a State needs to adopt for the realization of the right to health.

Having discussed in Part I what 'the right to the highest attainable standard of health' entails (i.e. the standards that derive from the right to health framework), Part II, consisting of chapters 5, 6, 7 and 8, reflects on the scope of this framework at the national level (i.e. Greece). More specifically, chapter 5 demonstrates that a primary recognition of Greece's commitment to the internationally guaranteed right to health is found in its Constitution. Additionally, the Constitution contains two Articles, that complement each other and entrench health both as a right and as a State's duty with particular consideration for the youth, elderly, disabled persons and for the relief of the needy. This constitutional framework is a valuable statement on which national legislation and policy practices should be based, while at the same time it indicates the State's overall commitment to the right to health. Nevertheless, this must also be accompanied by specific measures taken by the Greek State to implement such a commitment for the effective realization of the right to health by every individual in practice. In this regard, chapters 6, 7 and 8 focus on a selection of key themes that are of particular relevance to the country in question (i.e. Greece). Specifically, these Chapters explain how Greece's right to health commitment is reflected (or not) in practice and particularly in relation to the organization of its health infrastructure and to two vulnerable population groups, undocumented migrants and Roma children.

Chapter 6 illustrates that there is an apparent contrast between the international standards that Greece has ratified and what is being ultimately implemented by the Greek State within healthcare settings. Particularly, the Greek State designed and developed the national health system and its ensuing policy measures with the absence of the right to health framework. Meanwhile, especially from 2010 onwards notions underpinning the right to health do not receive considered and systematic attention in Greek law, policy and practice. Nonetheless, under its obligation to progressively realize the right to health (care) and in light of its

available (limited) resources the Greek State is required to strengthen its health infrastructure by placing emphasis on its primary structure (primary health care) and prioritize the needs of vulnerable individuals or groups. This implies that the Greek State must make a reasonable determination as to redress the existing health inequalities by setting concrete priorities and as to the way of allocating its scarce resources rather than using them as an excuse for its failure to do so. Last but not least, the Greek State retains ultimate responsibility to address two serious challenges that emerge and adversely influence the realization of the right to health (care) of individuals, when the health sector is poorly regulated and monitored: the growing presence and role of private health care providers within the public system; and the persistent corruption within this system.

Chapter 7 focuses on how the right to health (care) is being upheld for undocumented migrants residing in Greece. This chapter presents that the Greek State due to high levels of influxes of undocumented migrants combined with the increasing costs of health care has legislated limitations in access to health care for undocumented migrants. By this way, though, health-related policy-making and legislative action are linked with immigration controls and are dependent upon lawful residency within Greek territory. Seen from the perspective of the right to health framework such developments constitute a serious cause for concern and certain alarming issues can be detected as a result. The Greek State fails to consider the diverse health needs of undocumented migrants and to adopt context-sensitive policies to address them together with the living reality of these people (i.e. migrant-sensitive policies). Importantly, the denial of access to health care for undocumented migrants until an emergency situation arises, with the exception of undocumented migrant children, is inconsistent with the right to health framework. A continuous access to treatment and medicines for undocumented migrants is not ensured, exposing them to increased health risks. Lastly, chapter 7 highlights that along with the serious concerns raised in light of the internationally guaranteed right to health threats to the enjoyment of other human rights are also evident that have significant right to health implications.

Chapter 8 analyses the position of Roma children in relation to their right to health and access to health care. This chapter demonstrates that explicit integration of the internationally guaranteed right to health into national health law-policies for Roma children appears to be at a rudimentary level. Differences in life expectancy between Roma children and the general infantile population reflect the health inequalities of this group, which are of grave concern from a right to health perspective. At the same time they constitute a clear indication of the failure of the Greek State to comply with its right to health obligations concerning this

group. From a right to health perspective the Greek State does not take into account particular vulnerabilities and dependencies, relating to Roma children and their families, especially the circumstances in which they live, when health polices for this group are planned, designed and implemented. Importantly, it becomes apparent that realizing the right to health of Roma children is dependent not only on resource availability aligned with well-considered health-related decisions and actions on the part of the Greek State, but also on ensuring the enjoyment of the essential determinants of health. As such, the State's attempt to address the rising socio-economic health inequalities, which this vulnerable group experiences, is a both a pressing and a challenging task, if the Greek State wants to fully abide by its right to health obligations.

On the basis of the aforementioned findings, chapter 9 presents the conclusions of the study and contains a list of recommendations, involving the adoption of a framework law, containing certain elements underpinning the internationally guaranteed right to health and serving as a foundation for national legislation, regulations, ministerial decisions and protocols.

Samenvatting

Het recht op gezondheid
Een mensenrechtelijk perspectief met een case study over Griekenland

Zeven decennia na de erkenning van het recht op gezondheid in de preambule van de Grondwet van de Wereld gezondheidsorganisatie (1946) heeft dit recht een prominente positie verworven in het recht aangaande de rechten van de mens. Als een gevolg daarvan biedt dit recht de mogelijkheid om de gezondheid en het welbevinden van individuen wereldwijd te beïnvloeden. Ondanks het ontbreken van consensus over de precieze betekenis van dit recht, beoogt dit proefschrift te kijken naar de wijze waarop dit recht wordt geïmplementeerd op nationaal niveau. Dit vraagt om helderheid over de maatregelen die staten gehouden zijn om te nemen. Vanuit deze gedachte wordt in dit proefschrift geanalyseerd hoe het recht op gezondheid om nationaal niveau wordt gewaarborgd, waarbij in het bijzonder wordt gekeken naar de situatie in Griekenland. Vanwege deze vraagstelling bestaat dit boek uit twee delen (Deel I en Deel II) waarin achtereenvolgens de volgende vragen worden onderzocht:

(a) Welke primaire standaarden liggen besloten in het recht op gezondheid op grond van het recht inzake de rechten van de mens?
(b) Is het recht op gezondheid (effectief) geïmplementeerd in Griekenland (of niet)?

Deel I omvat drie hoofdstukken (hoofdstuk 2, 3 en 4) gericht op het formuleren van een toetsingskader om te kunnen bepalen of het recht op gezondheid juist is geïmplementeerd, met speciale aandacht voor het recht op *een zo goed mogelijke gezondheid* alsmede de gevolgen hiervan voor staten. In hoofdstuk 2 ligt de nadruk op het beschrijven van de ontwikkeling van de betekenis van dit recht in de internationale, regionale en nationale context.

In hoofdstuk 3 wordt nader ingegaan op de aard en reikwijdte van het recht

op gezondheid, de daarmee corresponderende verplichtingen voor staten en twee bedreigingen voor de realisatie van dit recht (privatisering en corruptie). Het doel van dit hoofdstuk is om verschillende aspecten inzake de inhoud van het recht op gezondheid te verduidelijken, zodat die kunnen worden gebruikt bij het onderzoeken of het recht op gezondheid juist is geïmplementeerd.

Hoofdstuk 4 richt zich op de betekenis van het recht op gezondheid voor staten. Daartoe wordt gekeken naar de werkzaamheden van verschillende internationale toezichthoudende organen. Het doel van dit hoofdstuk is te kijken naar de maatregelen die staten moeten nemen om het recht op gezondheid te verwezenlijken.

In Deel 2 (hoofdstukken 5, 6, 7 en 8) wordt stilgestaan bij de implicaties van het juridisch kader van het recht op gezondheid voor de nationale rechtsorde (te weten de Griekse nationale rechtsorde). Meer in het bijzonder wordt in hoofdstuk 5 geconstateerd dat het recht op gezondheid in de Griekse grondwet erkenning heeft gevonden. Het grondwettelijk raamwerk is een waardevol fundament om wetten en beleidsmaatregelen op te baseren gericht op het realiseren van het recht op gezondheid. In de hoofdstukken 6, 7 en 8 wordt op thema's ingegaan die van bijzonder belang zijn voor de juiste naleving van het recht op gezondheid in Griekenland.

In hoofdstuk 6 wordt geconstateerd dat er een schijnbaar contrast bestaat tussen de internationale standaarden die voor Griekenland gelden en de wijze waarop deze zijn geïmplementeerd op nationaal niveau. Allereerst heeft de Griekse overheid een nationaal gezondheidssysteem opgezet zonder zich rekenschap te geven van de normen die besloten liggen in het recht op gezondheid. Meer in het bijzonder werd vastgesteld dat vanaf 2010 de noties die ten grondslag liggen aan het recht op gezondheid geen weloverwogen en systematische aandacht meer hebben gekregen in de Griekse wetgeving en beleid op het terrein van de gezondheidszorg. Dit terwijl Griekenland verplicht is het recht op gezondheid geleidelijk aan te verwezenlijken, door de nadruk te leggen op de eerstelijnsgezondheidszorg en bijzondere aandacht te besteden aan de behoeften van de meest kwetsbare groepen. Op de Griekse overheid rust ook de eindverantwoordelijkheid om twee ernstige knelpunten op te lossen: de voortgaande privatisering van de zorg en de corruptie die de zorg bedreigt.

In hoofdstuk 7 wordt gekeken naar de naleving van het recht op gezondheid(szorg) ten aanzien van niet-gedocumenteerde vreemdelingen. Geconstateerd wordt dat Griekenland als gevolg van de hoge instroom van vreemdelingen in combinatie met de stijgende kosten voor de gezondheidszorg wetgeving heeft ingevoerd die de toegang tot zorg voor de leden van deze groep

belemmert. Gezondheidswetgeving en –beleid zijn gecombineerd met maatregelen ter beteugeling van de komst van migranten en gekoppeld aan de verblijfsstatus van vreemdelingen. Vanuit het perspectief van het recht op gezondheid vormen deze maatregelen een bron van grote zorg, De Griekse overheid laat ook na om de uiteenlopende gezondheidsbehoeften van niet-gedocumenteerde vreemdelingen in ogenschouw te nemen en maatregelen te nemen die zijn toegesneden op de context van niet-gedocumenteerde vreemdelingen.

Hoofdstuk 8 analyseert de positie van Roma-kinderen in relatie tot het recht op gezondheid en het recht op gezondheidszorg. Dit hoofdstuk laat zien dat de invoering van de standaarden inzake het internationaal erkende recht op gezondheid voor deze doelgroep zich op een rudimentair niveau bevinden. Tussen de gezondheid en levensverwachting van algemene bevolking en Roma-gemeenschap bestaan aanzienlijke verschillen. Dit is niet alleen een bron van zorg, maar laat ook zien dat Griekenland in gebreke blijft bij het verzekeren van de naleving van het recht op gezondheid. Als zodanig zijn de pogingen van de Griekse overheid om de toenemende sociaal-economische verschillen, die deze kwetsbare bevolkingsgroep ervaren, te verminderen een urgente en uitdagende noodzaak.

Op basis van voorgaande bevindingen, bevat hoofdstuk 9 de bevindingen van de studie en wordt daarin een lijst met aanbevelingen gepresenteerd. De maatregelen die genomen moeten worden om het recht op gezondheid te waarborgen zijn onder andere het aanpassen van wetgeving, van lagere regelgeving en van richtlijnen.

Curriculum vitae

Elisavet Athanasia Alexiadou was born in Thessaloniki (Greece) in 1983. She studied law at Aristotle University of Thessaloniki (AUTH) from where she obtained her Bachelor's degree in law. She holds an LLM in Medical Law (UK) and a MSc in Management of Healthcare Units, completed with university scholarship (Greece). Her PhD research at the Law Faculty (Institute of Public Law - programme: *Effective Protection of Fundamental Rights in a pluralist world*) of Leiden University (NL) focuses on national implementation of the right to health.

Since 2008, she is a Member of the Thessaloniki Bar Association and since 2013 she is lawyer at Court of Appeal. She is author of numerous academic articles and four books on health law and patients' rights, being officially distributed by the Greek Ministry of Education, Research and Religious Affairs at several academic institutions in Greece and students. Her latest book is entitled 'General Principles of Health Deontology' (University Studio Press 2012).